Expanding Opportunities & Reducing Barriers to Work: Final Summary Report

Evaluation of Pilot Projects to Promote Work and Increase State Accountability in the Supplemental Nutrition Assistance Program

(Evaluation of USDA, Supplemental Nutrition Assistance Program (SNAP) Employment and Training Pilots)

May 2022

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Gretchen Rowe, James Mabli, Julie Hartnack, and Kelley Monzella

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U.S. Department of Agriculture
Food Nutrition Service
1320 Braddock Place
Alexandria, VA 22314
Project Officer: Anita Singh
Contract Number: AG-3198-B-15-0002

Submitted by:
Mathematica
955 Massachusetts Avenue, Suite 801
Cambridge, MA 02139
Telephone: 617.301.8997
Project Director: James Mabli
Reference Number: 50142

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U.S. Department of Agriculture, Food and Nutrition Service, Office of Policy Support (OPS) and FNS Office of Employment and Training (OET)

Wesley Dean (fmr. OPS)
Danielle Deemer (fmr. OPS)
Marcie Foster (OET)
Rachel Gragg (OET)
Leigh Gantner (OET)
Moira Johnston (OET)
Kathryn Law (OPS)
Loretta Robertson (OET)
Anita Singh (OPS)
Kaila Wilson (fmr. OET)
Jackie Windfeldt (fmr. OET)

Members of the Technical Working Group

Ed Bolen (Center on Budget and Policy Priorities)
Stacy Dean (fmr. Center on Budget and Policy Priorities)
Amy Ellen Duke-Benfield (National Skills Coalition)
David Greenberg (University of Maryland, Baltimore County)
Alma Salazar (fmr. Los Angeles Area Chamber of Commerce)
Jeffrey Smith (University of Wisconsin-Madison)
Whitney Smith (JP Morgan Chase Foundation)

Mathematica

Jeremy Berman
Rachel Bleiweiss-Sande
Felita Buckner
Jim Cameron
Molly Cameron
Barbara Carlson
Julie Hartnack
Leah Jennings
Kristen Joyce
Miranda Kharsa
Wamaitha Kiambuthi
Patrick Lavallee
Kelley Monzella
Nora Paxton
Allison Pinckney
Milena Raketic
Linda Rosenberg
Gretchen Rowe

Laura Castner
Sharon Clark
Mason DeCamillis
Amy Defnet
Dallas Dotter
Mary Kay Fox
William Garrett
Cathy Lu
Timothy Luyster
Julia Lyskawa
James Mabli
Kim McDonald
Effie Metropoulos
Betsy Santos
Peter Schochet
Leah Shiferaw
Dan Thal
Andy Weiss
Dan Welsh

MDRC

Zuleka Abakoyas
Jonathan Bigelow
Alla Chaplygina
Stephen Freedman
Barbara Goldman
Gayle Hamilton (fmr.)
Brandon Hawkins
Richard Hendra
Gloriela Iguina-Colón
Anastasia Korolkova
Cynthia Miller
Frieda Molina
David Navarro
Keith Olejniczak
Nikki Ortolani
Liza Paudel
Alexandra Pennington
Natasha Piatnitskaia
Stephanie Rubino
Kelsey Schaberg
Ebony Scott
Susan Scrivener
Diane Singer
Makenzi Sumners
Kemar Taylor
Betsy Tessler
Donna Wharton-Fields

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Glossary

ABAWD	Able-bodied adult without dependents. 18- to 49-year-old adult who is not disabled and does not have dependents
BCCS group	Basic Community College Services treatment group in Mississippi. One of two treatment groups in Mississippi
CBA	California Bridge Academy. The SNAP Employment and Training pilot implemented in California
CBO	Community-based organization
Control group	A group of individuals enrolled in a SNAP Employment and Training (E&T) pilot that was eligible for services available through existing SNAP E&T programs if such programs were available to the control group in the pilot location
ECCS group	Enhanced Community College Services treatment group in Mississippi. One of two treatment groups in Mississippi
EDGE	Ethics, Discipline, Goals, Employment. The SNAP Employment and Training pilot implemented in Mississippi
EleVAte	The SNAP Employment and Training pilot implemented in Virginia
EPIC	Employment Opportunities, Personalized Services, Individualized Training, and Career Planning. The SNAP Employment and Training pilot implemented in Illinois
ES group	Existing services control group in California. One of two control groups in California
ESL	English as a Second Language
Food security	Having access at all times to enough food for an active, healthy life. Individuals who experienced food access limitations due to lack of money or other resources are said to be food insecure
GED	General Education Development. A group of subject tests which, when passed, certify that the test taker has high school-level academic skills
GOALS	Generating Opportunities to Attain Lifelong Success. The SNAP Employment and Training pilot implemented in Kansas
JFI	Jobs for Independence. The SNAP Employment and Training pilot implemented in Vermont
LWIA	Local workforce investment area. A group of one or more counties that provide workforce development services
NS group	No services control group in California. One of two control groups in California
P2P	Paths 2 Promise. The SNAP Employment and Training pilot implemented in Kentucky
Random assignment	An experimental technique for assigning individuals enrolled in a SNAP Employment and Training pilot into research groups (a treatment or control group)

Research group	A group of individuals enrolled in a SNAP Employment and Training pilot that was either eligible for enhanced services (a treatment group) or eligible for services available through existing SNAP E&T programs where available (a control group)
RISE	Resources to Initiate Successful Employment. The SNAP Employment and Training pilot implemented in Washington
SNAP	Supplemental Nutrition Assistance Program. A Federal nutrition assistance program
SNAP E&T	A program that assists SNAP participants in obtaining employment by providing services, such as job search assistance, job skills training, education, work experience, or workfare, and supports, such as assistance with transportation and child care costs
SNAP Works 2.0	The SNAP Employment and Training pilot implemented in Georgia
TANF	Temporary Assistance for Needy Families. A Federal grant program designed to help needy families achieve self-sufficiency
Treatment group	A group of individuals enrolled in a SNAP Employment and Training pilot that was eligible for the enhanced set of services developed under the pilot
UI	Unemployment insurance. A Federal program to provide unemployment benefits to eligible workers
USDA	U.S. Department of Agriculture
Very low food security	A severe form of food insecurity characterized by disrupted eating patterns and reduced food intake
WBL	Work-based learning
WIOA	Workforce Innovation and Opportunity Act
WONDER	Work Opportunity Networks to Develop Employment Readiness. The SNAP Employment and Training pilot implemented in Delaware
Work registrant	SNAP participant who has not met any Federal exemptions from SNAP work requirements and is therefore required to register for work

Executive summary

The Supplemental Nutrition Assistance Program (SNAP) is the primary source of nutrition assistance for many individuals and families with low incomes. SNAP provides monthly benefits to help participants obtain adequate access to food; for some program participants, it also provides work supports through SNAP Employment and Training (E&T) programs to help them become economically self-sufficient. Although States are required to administer a SNAP E&T program, they have flexibility in determining and designing its services and activities. States typically offer SNAP participants some case management and support services, and a range of activities that include job search assistance or training, occupational skills training, and basic education.

Because SNAP E&T programs are so varied and are administered at the State or local level, information about the most effective approaches for helping SNAP participants gain skills and find work is limited. For this reason, as part of the Agricultural Act of 2014, Congress authorized and funded the SNAP E&T pilots to test innovative strategies for connecting SNAP participants with jobs that would increase their incomes and reduce their need for public assistance. In 2015, the U.S. Department of Agriculture's Food and Nutrition Service (FNS) awarded pilot grants to 10 States—California, Delaware, Georgia, Illinois, Kansas, Kentucky, Mississippi, Vermont, Virginia, and Washington—which represented diverse service areas and populations. The pilots varied in whether they operated statewide or only in selected areas, and whether they focused on urban communities, rural communities, or both. The majority of individuals the pilots targeted were unemployed or underemployed and faced significant barriers to employment, such as being homeless or having a criminal history or substance use disorder. Pilots generally expanded the types and amounts of services provided through States' existing SNAP E&T programs. Services typically included (1) a comprehensive skills or clinical assessment to determine an individual's work readiness, skills, and barriers to employment; (2) case management services that developed and supported a detailed individualized work and barrier-reduction plan; and (3) support services,[1] such as transportation assistance, child care, housing assistance, and training or work supplies that helped reduce barriers to both engagement in the pilot and employment. The pilots also offered a range of employment and training-related activities, such as independent job search, job readiness training, job search assistance, basic education, occupational skills training, and work-based learning opportunities (such as subsidized employment, work experience, internships, and work study).[2] Each pilot enrolled 3,000 to 7,000 individuals, for a total of 44,359 individuals across the 10 pilots.

Services are resources provided or administered to individuals, such as assessments, case management, and support services.

Activities are employment or training-related events in which individuals participate, such as job search assistance training, basic education, occupational skills training, or work-based learning.

Congress also required a rigorous, longitudinal evaluation of the pilots to assess whether the innovative strategies they used were successful in connecting SNAP participants with jobs that increased their incomes and reduced their need for public assistance benefits. This report synthesizes and summarizes findings from the 10 pilot-specific final

[1] Referred to as participant reimbursements in the SNAP E&T program; however, for this report, we describe the package of services as support services.

[2] For simplicity, we refer to the group of services and activities offered by the pilots as "pilot services" in this report; we continue to differentiate them when describing specific sets of services and activities.

evaluation reports. The pilot-specific reports provided a detailed description of the pilot's design and implementation and, using data for up to three years following random assignment, examined the services individuals received and assessed the effectiveness of those services in improving individuals' outcomes. The final evaluation reports also included findings from the cost-benefit analysis which itemize specific monetary costs and benefits of pilot services and assess whether the benefits offered through the pilot were large enough to offset their costs.

A. Evaluation overview

The evaluation included the following four components:

1. An ***implementation analysis*** that documented the context and operations of each pilot
2. A ***participation analysis*** that examined the characteristics, participation levels, and service paths of individuals in the pilots
3. An ***impact analysis*** that identified what works, and for whom, by examining impacts on employment and earnings; public assistance receipt; and other outcomes, such as food security, health, well-being, and housing
4. A ***cost-benefit analysis*** that estimated the return on each dollar invested in the pilots

The evaluation used an experimental research design in which individuals eligible for SNAP E&T who were enrolled in the pilot were randomly assigned into treatment and control groups in roughly equivalent numbers. Individuals assigned to the treatment group were eligible for the enhanced set of services developed under the pilot, whereas control group members were eligible for services available through the existing SNAP E&T program in the State.[3] Individuals in both the treatment and control groups continued to be eligible for any other employment and training services available in their communities. Through random assignment, the two groups were, on average, similar across a range of characteristics at the time they enrolled in the pilot. They differed only in the services they subsequently were eligible to receive. This research design allows us to confidently attribute differences in outcomes between the groups to the enhanced services rather than other potential causes.

For the evaluation, we collected and analyzed several types of data, including the following:

- ***Implementation data*** from interviews with grantee, partner, and provider staff and treatment group members to understand the pilot planning and implementation and provide context for other analyses
- ***Administrative service use data*** to describe treatment group members' participation in pilot services
- ***Unemployment insurance (UI) wage records*** to measure employment and earnings
- ***SNAP administrative data*** to measure participation in SNAP, Temporary Assistance for Needy Families (TANF), and Medicaid, and the amount of SNAP and TANF benefits
- ***12- and 36-month follow-up survey data*** from individuals enrolled in the pilot to provide additional information about service receipt, employment, and earnings, as well as food security, health, well-being, and housing status

[3] One of the two control groups in California, referred to as the No Services (NS) control group, did not receive any SNAP E&T services. Also, Kentucky did not administer a SNAP E&T program in any of the pilot counties, and Illinois, Kansas, and Virginia did not administer a program in some pilot areas.

- ***Cost data*** from grantees and providers, and time-use data to estimate the cost of services and net costs and benefits to individuals, the government, and society

B. Pilot overview

All of the pilot grants were awarded to State SNAP agencies in March 2015. Most grantees saw the pilots as an opportunity to develop and provide more intensive services than were currently available or fill a gap in existing services by providing them in areas where SNAP E&T was not available. Some used the pilots as an opportunity to expand their SNAP E&T services to align with what they offered in TANF or Workforce Innovation and Opportunity Act (WIOA) programs, whereas others created services that did not exist at all in the pilot areas.

Participation in SNAP E&T was voluntary in 7 of the 10 pilots (Exhibit ES.1). Georgia, Illinois, and Mississippi administered mandatory SNAP E&T programs in some or all of the pilot counties. In mandatory E&T programs, individuals enrolled in the pilot were required to participate in E&T activities (through either the pilot or the existing SNAP E&T program) to retain their SNAP benefits. Whether in the treatment or control group, those who did not comply with these requirements were sanctioned—meaning they lost their benefits and were ineligible to participate in SNAP (and the pilot) for a State-determined number of months or until they became compliant.

Exhibit ES.1. Key characteristics of pilots

Pilot	Program type	Location	Target population
CA	Voluntary	Fresno County	Work registrants
DE	Voluntary	Statewide	New work registrants
GA	Mandatory	9 metropolitan counties[a]	ABAWDs
IL	Mandatory and voluntary[b]	33 counties served by 7 local workforce investment areas	Work registrants who were unemployed or underemployed with low skills or limited work experience, and individuals working 30 or more hours per week needing skill upgrades
KS	Voluntary	35 counties	Work registrants
KY	Voluntary	8 southeastern rural counties	Work registrants
MS	Mandatory	29 counties served by 5 community colleges	ABAWDs
VT	Voluntary	Statewide	New work registrants with barriers, including substance use or mental health disorders, housing instability, or criminal histories
VA	Voluntary	24 localities served by 7 community colleges	Work registrants
WA	Voluntary	4 urban and rural counties	New work registrants who were long-term unemployed, homeless, veterans, noncustodial parents with child support arrears, or had limited English proficiency and barriers to employment

[a]Originally, there were 10 counties, but Georgia stopped enrolling individuals in Cherokee County in January 2017.

[b]Most individuals enrolled in the pilot (in both the treatment and control groups) were mandatory work registrants.

ABAWDs = able-bodied adults without dependents.

Most of the pilots operated in selected areas of the State. Pilots that did not operate statewide generally targeted regions that were most in need of services, had the largest target populations, or had providers that could readily offer enhanced services. The areas served ranged from 1 county in California to 35 counties in Kansas. Most of the pilots served a mix of urban and rural communities, but pilots in Kentucky and Vermont primarily targeted rural areas.

Pilots primarily targeted SNAP participants who did not meet a Federal exemption from general work requirements and were considered "work registrants."[4] Several pilots targeted a subset of these individuals, such as new work registrants (work registrants in a household recently approved to receive SNAP benefits). Two pilots targeted able-bodied adults without dependents (ABAWDs) because these individuals were mandatory participants in both States, and SNAP E&T program services could help them meet their work requirements. Two other pilots targeted work registrants who had significant barriers to employment, such as those with long-term unemployment, substance use disorders, mental health disorders, criminal histories, or unstable housing.

Grantees generally contracted with partner organizations to provide support in developing, administering, or monitoring the pilot, and with providers to deliver pilot services for treatment group members. Partners included community-based organizations, leadership councils, or university boards or centers. Providers included organizations offering WIOA programs, employment and occupational skills training in the community (for-profit or not-for-profit), adult basic education, and postsecondary education or training (community colleges). Grantees and their partners and providers began enrolling individuals in the pilots between January and April 2016, depending on the pilot, and provided services for up to three years (ending between December 2018 and April 2019).

Characteristics of individuals enrolled in the pilots. The types of individuals enrolled in the pilots reflected the diversity of the populations they targeted. In six pilots, for example, individuals were more likely to be male than female (Exhibit ES.2). In only four pilots were more than 20 percent of enrollees living in households with children. Across the pilots, the average age of those enrolled ranged between 32 and 39 and about one-quarter of individuals did not have a high school diploma. Finally, in all pilots, most of the individuals who enrolled were not employed at the time of random assignment—only 5 to 28 percent of all individuals were currently working. However, many were employed in the two years preceding random assignment; 35 to 40 percent were employed in just a few quarters during this period and 14 to 32 percent were employed for at least seven out of the preceding eight quarters.

[4] Work registrants are SNAP participants who have not met any Federal exemptions from SNAP work requirements and are therefore required to register for work. Federal exemptions apply to individuals who are younger than 16 or older than 59, physically or mentally unfit for employment, subject to and complying with work requirements for another program, a caretaker of a dependent child younger than 6 or an incapacitated individual, participating in a drug or alcohol treatment and rehabilitation program, employed at least 30 hours a week, or enrolled at least half time in a recognized school or training program.

Exhibit ES.2. Characteristics of individuals at enrollment

Pilots	Female	Average age (yrs)	Without a high school diploma	Living in a household with children	Married or cohabiting	Living in rural area	Currently employed	Never/seldom employed	Sometimes employed	Consistently employed
CA	60%	35	24%	47%	17%	2%	22%	43%	37%	20%
DE	42%	34	24%	19%	7%	5%	12%	35%	42%	22%
GA	48%	33	21%	5%	4%	0%	6%	39%	37%	24%
IL	35%	34	23%	10%	4%	1%	7%	46%	40%	14%
KS	61%	37	23%	42%	14%	10%	16%	31%	39%	30%
KY	59%	33	24%	51%	30%	83%	14%	47%	36%	17%
MS	47%	32	31%	3%	28%	20%	5%	48%	37%	18%
VT	44%	39	19%	14%	11%	37%	14%	44%	37%	20%
VA	74%	37	20%	55%	11%	12%	28%	33%	35%	32%
WA	43%	38	27%	20%	11%	1%	8%	48%	36%	16%

Source: SNAP E&T random assignment system (January 2016 through September 2018 data) and UI wage records.

Note: Tabulations include all treatment and control group members who enrolled in the pilot and did not subsequently choose to revoke their consent to participate in the evaluation. "Currently employed" measures employment reported by the individual at the time of enrollment. Based on UI wage record data, the terms "consistently employed," "sometimes employed," and "never or seldom employed" indicate an individual was employed in at least seven out of eight quarters before enrollment, two to six quarters out of the eight quarters before enrollment, or at most one out of eight quarters before enrollment, respectively.

Existing SNAP E&T program services. States that had an existing SNAP E&T program generally provided a limited set of services (such as case management or support services) and activities (such as training or education programs). Existing SNAP E&T programs in those pilot States with programs offered some level of case management and support services, but case management often focused on intake and compliance, and supports generally consisted of small transportation payments (about $25 per person per month). Most programs focused on independent or structured job search (job search assistance and job placement) and workfare. Existing SNAP E&T programs in five pilot States also offered education and occupational skills training activities. In general, however, only a small proportion of eligible individuals participated in these activities.

Pilot services. Grantees had considerable flexibility in designing their pilot models and identifying the services and activities to offer. Some pilots offered different "tracks" of pilot services, which individuals entered based on interests or requirements. Some models required an up-front soft skills or life skills course for some individuals before they could move into other activities and/or focused up front on reducing barriers to employment before assigning individuals to activities—a process that could take weeks or even months. Finally, some pilots offered a range of services and activities with no specific pathway, tailoring a package of services to the needs and interests of each individual.

All of the pilots offered treatment group members more services than were available under existing SNAP E&T programs. Pilots generally offered intensive case management, which could include weekly or monthly check-ins with individuals. When individuals accessed services from multiple organizations, a few pilots used a team-based approach to coordinate case management across providers. Also, although existing SNAP E&T programs offered support services (mainly transportation and child care assistance,

which are mandated), the pilots offered more generous and a broader array of supports, including housing, personal care items (such as eyeglasses or dentures), occupational skills training, and work supplies (for example, uniforms, books, clothes, or tools). The supports offered sought to help individuals reduce barriers to employment and support their involvement in activities.

Although the models differed across the pilots, the range of activities they offered were similar. Many continued to offer independent job search, but most focused on more structured job search activities such as job search assistance, job readiness training, or job search training. Virtually all pilots included providers that offered occupational skills training and basic education or referred those interested in these activities to providers in the community that were not part of the pilot. Seven pilots offered work-based learning placements. Some also offered additional activities, such as financial or digital literacy, workfare, or postsecondary education.

Types of activities

Independent job search: unstructured job search, generally self-directed with minimal assistance

Job search/readiness assistance or training: job readiness workshops, job placement assistance, structured job search assistance, skills-building training (soft skills, interview skills, life skills), job search training

Basic education: basic or remedial education, such as adult basic education, General Education Development (GED) or high school equivalency preparation instruction, reading or math boost-ups, and English as a second language (ESL)

Occupational skills training: short-term occupational or vocational skills training

Work-based learning: employment opportunities to provide individuals with general or specialized work experience that could be paid or unpaid, including subsidized employment, work experience, internships, and work study

Other activities: a range of activities that were not the primary focus of the pilots or that few individuals received, including postsecondary education (for obtaining a degree), financial literacy counseling, digital literacy, and workfare

C. Pilot services received by treatment group members

In most pilots, more than 80 percent of the individuals assigned to the treatment group engaged in the pilot, meaning they started pilot intake, assessments, or an employment or training-related activity after random assignment (Exhibit ES.3). Although initial engagement rates were high, the rates at which treatment group members ultimately started an employment or training-related activity after they completed intake and assessments were lower; in seven pilots, fewer than 70 percent of treatment group members started an activity. Job search/readiness assistance or training had the highest take-up rates across pilots—50 percent or more of individuals in several pilots. Fewer individuals participated in the other activities, usually less than 25 percent.

Although not all treatment group members participated in activities, most did receive case management and support services while engaged in the pilot. More than 90 percent of individuals in seven pilots had at least one contact with a case manager. The percentage of individuals who received at least one support service varied much more across the pilots, but generally 50 to 80 percent of treatment group members received a support service while in the pilot—most commonly transportation assistance.

In six pilots, 30 percent or more of treatment group members exited the pilot within the first three months after random assignment, and between 50 to 80 percent exited by the sixth month (not shown). In the other four pilots, individuals remained in the pilot much longer, with many still in the pilot at 12 months. Across all pilots, most individuals exited before completing all activities, or they became ineligible for the pilot due to losing SNAP eligibility, receiving TANF, or not complying with pilot rules and being

terminated. In most pilots, less than about one-third of individuals exited the pilot due to completing all pilot activities or finding employment (based on self-reporting).

Exhibit ES.3. Percentage of individuals who engaged in pilot services

	CA	DE	GA	IL	KS	KY	MS (ECCS)	MS (BCCS)	VT	VA	WA
Engagement in the pilot	94	68	58	69	96	99	69	95	96	83	91
Started any employment or training-related activity	79	40	55	66	95	55	67	58	89	61	56
Independent job search	[a]	[a]	51	57	63	9	12	13	[a]	31	14
Job search/readiness assistance or training	72	33	49	29	71	[a]	61	16	86	54	46
Basic education	22	5	1	12	6	4	10	16	2	15	7
Occupational skills training	32	13	6	46	23	27	24	27	29	18	15
Work-based learning	5	4	0	30	[a]	38	16	13	8	[a]	1
Had contact with case manager	97	100	93	99	NA	97	70	76	87	94	94
Received a support service	45	58	25	57	79	77	90	85	70	50	63

Source: SNAP employment and training evaluation administrative service use data.

Notes: NA indicates that neither the grantee nor provider were able to provide the data.

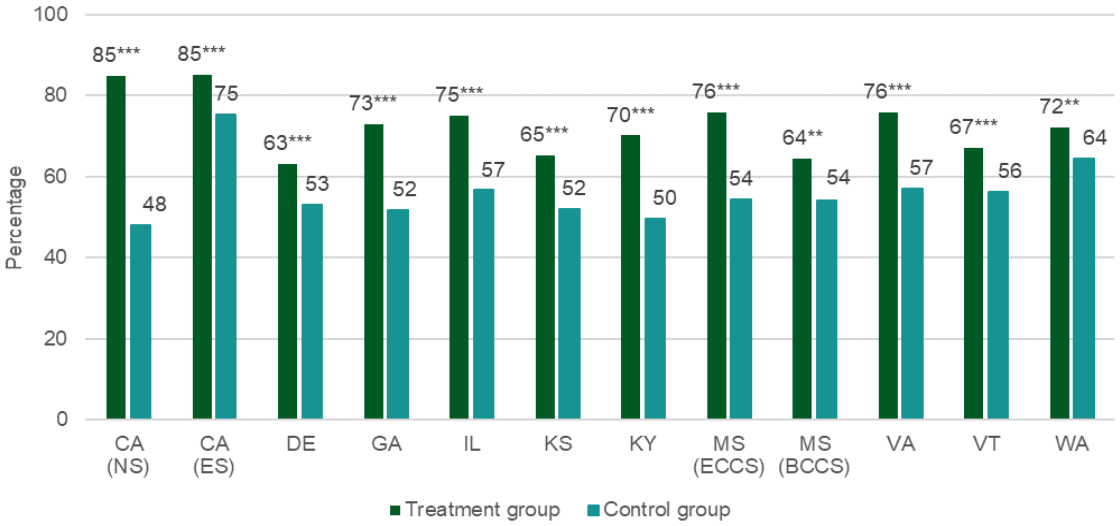
[a]Indicates the activity was not offered.

D. Differences between treatment and control groups in service receipt

When comparing the participation of treatment and control group members in any employment or training services or activities available to them, we find that treatment group members were more likely to participate in job search training or assistance activities and education or training activities (Exhibit ES.4). They were also generally more likely to participate in specific components of education or training activities, including general job skills training, occupational skills training, education, and work-based learning activities. Treatment group members were more likely than control group members to complete these activities as well (Exhibit ES.5), and for all pilots except California (ES) and Washington, they were more likely than control group members to receive occupational certificates or licenses.

In 8 of the 10 pilots, treatment group members received case management at higher rates than control group members and had more case management contacts on average (not shown). Treatment group members were also more likely to receive support services overall and to receive specific types of support services such as transportation assistance, and support for work items such as uniforms, boots, clothes, or tools.

Exhibit ES.4. Percentage of treatment and control group members who participated in any pilot, existing SNAP E&T, or community-offered activities



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

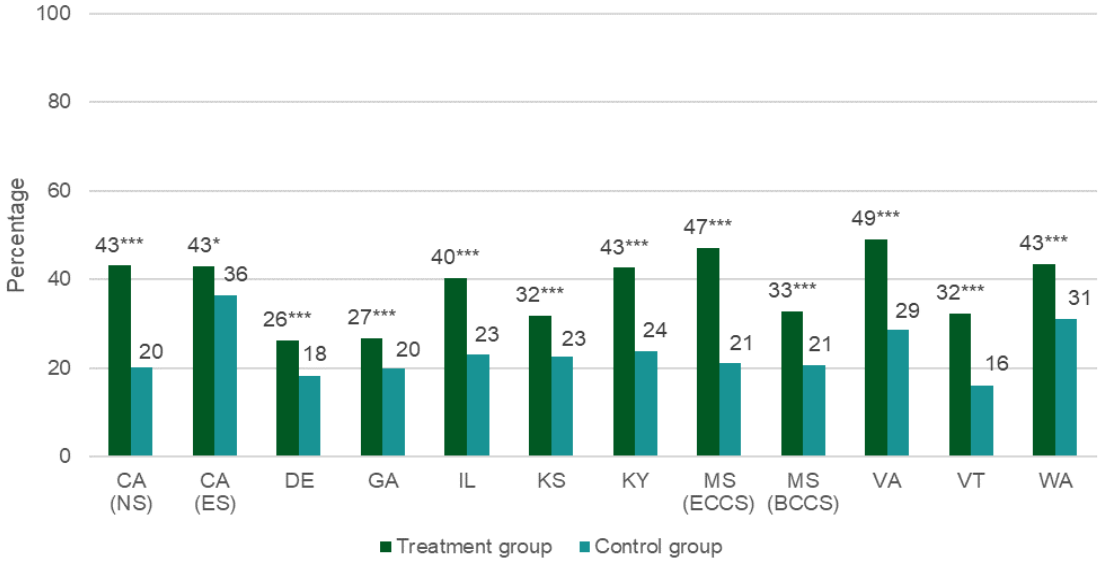
***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = Basic Community College Services; ECCS = Enhanced Community College Services; ES = Enhanced Services; NS = No Services

Exhibit ES.5. Percentage of treatment and control group members who completed education and training activities



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = Basic Community College Services; ECCS = Enhanced Community College Services; ES = Enhanced Services; NS = No Services

E. Impacts of pilot services on individuals' outcomes

The enhanced pilot services offered to treatment group members led to an increase in earnings in the two-year period (Years 2 and 3) in 3 pilots (California, Mississippi, and Virginia), but had no effect in the other 7 pilots. In all 10 pilots, both treatment and control group members experienced increases in average earnings over time. Increases in earnings ranged from about $2,000 to $4,000 over the two-year period.

These increases in earnings generally did not translate into reductions in SNAP participation, but some pilots did have an impact on participation. The availability of treatment group services decreased the likelihood of SNAP participation by 3 percentage points in Illinois and increased the likelihood of SNAP participation in two pilots (Mississippi and Virginia) by 2 to 4 percentage points.

Exhibit ES.6. Summary of treatment–control differences in earnings, SNAP participation, employment, and food insecurity in Years 2 and 3 after random assignment

	CA (NS)	CA (ES)	DE	GA	IL	KS	KY	MS (ECCS)	MS (BCCS)	VA	VT	WA
Earnings	+	ns	ns	ns	ns	ns	ns	+	+	+	ns	ns
Employment	+	ns	ns	ns	+	+	+	ns	ns	ns	+	ns
SNAP participation	ns	ns	ns	ns	—	ns	ns	ns	+	+	ns	ns
Food insecurity	—	ns	ns	ns	ns	ns	ns	ns	—	ns	ns	ns

Source: SNAP employment and training evaluation UI wage records, 12- and 36-month survey data, and SNAP administrative data, weighted data.

Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no services" and "existing services" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the differences between the ECCS and BCCS treatment groups in Mississippi and the control group. Impacts on earnings were based on UI data for Mississippi. Impacts on employment were based on UI and survey data for Kansas and on UI data only for Kentucky; all other impacts on earnings and employment were based on survey data. Household food security status was measured over the 30 days before 36-month survey.

\+ indicates that difference between research groups is positive and statistically significant at the 0.10 level.

— indicates that difference between research groups is negative and statistically significant at the 0.10 level.

ns indicates that difference between research groups is not statistically significant at the 0.10 level.

Notably, in five pilots (California [NS], Illinois, Kansas, Kentucky, and Vermont), the enhanced services offered to the treatment group increased employment over the two-year period. Increases in employment ranged from 4 to 6 percentage points. Out of the five pilots that had impacts on employment, four (all except California [NS]) did not have a corresponding impact on earnings.

The increase in earnings translated into reductions in food insecurity in California (NS) and in very low food security in California (NS) and Mississippi (BCCS). There were no other impacts on food security status.

F. Pilot costs and cost-benefit analyses

The total costs of the pilots—including those for the planning period, recruiting treatment and control group members, and providing treatment group services—ranged from $6,813,186 in Georgia to $23,362,819 in Washington. The cost-benefit analysis compared the benefits individuals received through earnings and public assistance with the average costs of all services and activities treatment and control group members received per individual through the pilots, existing SNAP E&T programs, or the

community. The costs of all services and activities treatment group members received generally were about 25 percent higher than those of pilot services alone (between about $2,000 and $9,000 per individual, on average), suggesting that treatment group members received some of them from existing SNAP E&T or community resources. The costs of all services and activities control group members received through existing SNAP E&T programs or the community (between about $1,000 and $3,000 per individual, on average) were less than a third of the costs for treatment group members.

We examined treatment group benefits and costs relative to the control group from multiple perspectives, including those of (1) individuals enrolled in the treatment groups, (2) government and taxpayers, and (3) society as a whole. The latter represents the sum of the other two perspectives. Only three pilots had a positive net benefit to society: Mississippi (by about $300 for the ECCS and BCCS groups, respectively, according to UI wag records), Georgia (by about $100 according to survey data), and California (by about $1,000 compared to the NS control group, according to survey data). The rest had an overall negative net benefit, meaning the costs of the treatment group services were more than the benefits to society during the 36-month follow-up period according to UI wage records and 36-month follow-up survey data. The negative net benefit ranged from $400 to $6,000 per individual across pilots and data sources. Although treatment group services generally led to a net benefit for individuals in most pilots due to higher earnings and receipt of support services (about $100 to $5,000 per individual across pilots and data sources), the costs of these pilot services to government and taxpayers were far larger (about $1,000 to $6,000 per individual). Therefore, the benefits did not offset the costs of the services, on average, during the 36-month follow-up period.

G. Placing findings in the context of the workforce evaluation literature

The study findings are consistent with the previous literature that has often found small or no labor market effects of employment and training programs for low-income populations offering similar services as the pilots. The literature suggests that programs serving low-income populations can typically engage individuals and increase their receipt of services relative to those received by the study control groups in their local areas. The differences for service receipt can be large, especially for receipt of occupational skills training and subsidized employment, translating into positive effects on the percentages of individuals who participate in training activities and the attainment of associated certificates and credentials. However, few of the studies have found that the programs lead to long-term increases in earnings or independence from public assistance (at least over the time period covered by many studies, which is typically less than four years).

There are notable exceptions, however, that show that the types of activities and services offered by the pilots such as subsidized employment, education, job search assistance, case management, and support services are effective in improving labor market outcomes. As a result, it is important to understand how take-up and completion of pilot activities and receipt of services, as well as challenges experienced in implementation, may have contributed to the evaluation findings.

H. Discussion of the findings

The enhanced services offered to treatment group members increased earnings in three pilots. Despite not all of the pilots having positive impacts on earnings, the enhanced services in all pilots increased the percentages of individuals who received case management and support services relative to the control group, as well as the percentage of those who participated in employment or training-related activities. These accomplishments are notable given the prevalence and extent of barriers many treatment group members faced—across all pilots only 5 to 28 percent of individuals were employed at the time of

random assignment, and 19 to 30 percent did not have a high school diploma. The higher rates of receipt of case management and support services among treatment group members in some pilots, particularly transportation assistance, may have allowed them to overcome barriers associated not only with starting employment or training-related activities, but also sustaining participation over time and ultimately completing those activities. Indeed, in many pilots, treatment group members participated for a greater number of months and a greater number of hours per week than the control group, and had higher completion rates.

Discussion of pilots with earnings impacts. The presence of impacts on earnings in California (NS), Mississippi, and Virginia likely reflects that these pilots had the largest differences between treatment and control groups in starting and completing employment or training-related activities, and in receipt of case management and support services.

The positive findings in California are not entirely surprising given the control group was not offered any existing SNAP E&T program services and had to seek out services in the community on their own. In Kentucky, which also did not offer existing SNAP E&T services to the control group, those in the control group were enrolled by providers that also delivered services to anyone in the community, including the control group. However, in California, the control group was not enrolled by provider staff and therefore, had to learn about and seek out services that were available in the community on their own, if they wanted them. This likely contributed to the large differences in participation and completion of activities between the CBA and NS control group in California.

In Mississippi and Virginia, the process for offering services may have led to less drop off and increased participation in and completion of activities. Both pilots primarily offered all of their services and activities at one set of locations—community colleges. Although there often was drop off between enrollment and individuals first going to the community college (SNAP agencies conducted pilot enrollment and referred individuals to the community college), once there, the community college provided case management, support services, training, adult education, and work-based learning opportunities (in Mississippi). Treatment group members did not have to work with multiple providers or receive referrals to other locations to obtain the full package of services. This "one-stop" type of provider may have contributed to treatment group members staying in services and participating in activities at higher rates than the control groups who likely would have had to work with multiple providers to obtain similar services.

Discussion of pilots without earnings impacts. The lack of an impact on earnings in the remaining pilots may reflect a range of potential factors:

- I**n Delaware, Georgia, Kentucky, and Washington, only 40 to 56 percent of treatment group members started an employment or training-related activity, which was lower than expected.** The fact that one-third to more than half of treatment group members in these pilots did not participate in a substantive activity could have diluted the impacts on outcomes such as earnings.
- **In Illinois, despite not having an impact on earnings in Years 2 and 3, the rate of participation in employment and training-related activities and the differences between research groups in rates of participation and completion were similar to those in pilots that had impacts.** An impact on earnings did emerge in Year 3, however, possibly reflecting that Illinois had the largest percentage of individuals participating in occupational skills training across the pilots. Engagement in training activities likely reduced the chances of moving into higher-paying jobs during part of the pilot period, making it less likely to observe an impact on earnings in the two-year period.

- **In Vermont and Kansas, many treatment group members started an employment or training-related activity, but differences between treatment and control groups in participation and completion of activities were small.** In addition, Vermont served SNAP participants with severe barriers to employment, but the treatment group was only slightly more likely than the control group to receive case management and support services.
- **Earnings impacts might have depended on the type of activities in which individuals participated.** Pilots offered individuals in the treatment groups a wide range of activities. Earnings impacts may not be apparent when measuring the effectiveness of all offered activities as a whole, but that finding does not mean specific activities, such as occupational skills training or work-based learning, were ineffective.

Context for pilots with increased employment but no impact on earnings. Although none of these pilots' services resulted in an impact on earnings, some—Illinois, Kansas, Kentucky, and Vermont—did increase employment. There is not one consistent reason why these pilots were able to increase employment but had no impact on earnings. Instead, each site had its own implementation and environmental factors that affected the findings. For example, Kansas had delays in establishing occupational skills training and ultimately had limited training options. This resulted in less than one-quarter of treatment group members participating in training and over 70 percent of them participating primarily in job-readiness activities and independent job search. As a result, many treatment group members became employed, but many may not have had the skills, education, or certifications that could lead to higher-paying jobs. This likely resulting in no impacts on earnings. Similarly, Illinois faced difficulty in matching individuals with appropriate providers and activities, particularly early in the pilot. Although Illinois took steps to address this, it often resulted in individuals failing to remain in and complete substantive activities, such as occupational skills training. Although a relatively large number of treatment group members started occupational skills training, only about half of those completed it, while many individuals participated in and completed job search or job search training.

In Kentucky, the economic conditions likely played a significant role in the lack of impacts on earnings. Historically, the area has relied heavily on the coal mining industry, which has declined dramatically over the last decade. What was left were mainly retail, food industry, or other low- or minimum-wage jobs. Therefore, even when individuals completed training or obtained work experience, there were few employment opportunities available to them. They could find a job—most employers in the area needed employees—but it was unlikely they could earn much more than minimum wage, even when they had training.

Although all pilots served individuals with barriers to employment, Vermont focused on those with severe barriers. The pilot model emphasized case management and support services, with activities being offered after individuals had reduced their barriers enough to begin to build their skills. Pilot staff discussed the difficulty of overcoming barriers related to transportation, substance use, mental health, criminal histories, and homelessness. Because of this, many individuals were not ready for employment or were severely constrained in the types of employment for which they could apply. The amount of time required to reduce severe barriers, become employed, and obtain higher-paying jobs may reflect why the pilot showed a higher rate of employment for the treatment group but not higher average earnings. With many treatment group members participating in activities in Year 3 and employment impacts just beginning to emerge in that year, a greater amount of time may be required in which to observe earnings impacts among such a highly-barriered population.

Context for pilots with no employment or earnings impacts. Three pilots—Delaware, Georgia, and Washington—did not result in impacts on employment or earnings. A range of implementation issues likely contributed to these findings. For example, in Delaware, the lack of an impact may reflect that only 40 percent of treatment group members started an employment or training-related activity, meaning nearly two-thirds did not participate in a substantive activity. Delaware also struggled to consistently and fully offer two of their three industry-specific tracks throughout the pilot period, and only about 100 people were enrolled in each of those tracks. Thus most of the treatment group did not participate in the industry-specific tracks and received primarily job placement services (support with developing resumes, preparing for job interviews, and offering job leads) instead, where they generally did not develop new skills. These activities were similar to those received by the control group. The treatment group members likely were receiving more intensive case management and general support in obtaining jobs, but the percentage of them becoming employed, and the wages for those jobs, may not have been much different from what was available to the control group.

Similarly, Georgia faced implementation challenges that limited overall engagement and skill building, which likely contributed to finding no impacts on employment or earnings. First, individuals were enrolled in the pilot by one agency, then referred to another for orientation and upfront job search training. Having multiple referral points can create opportunities for people to drop out of the program, and, in fact, over 40 percent of the treatment group never attended an orientation after enrollment. Second, Georgia required that individuals participate in job search training activities before being referred to education or occupational skills training (which was offered by another provider at a different location). Staff suggested that some individuals likely left the program before being offered education and training; some treatment group members suggested that the training options available were not geared towards their needs or interests. These factors likely contributed to only about 6 percent of the treatment group participating in occupational skills training; without obtaining additional skills, individuals were less likely to obtain higher wage jobs.

Washington faced a different implementation challenge—the lack of difference in the services the treatment group and control group received. DSHS faced a unique challenge when this pilot started, as it already operated a robust SNAP E&T program in the State. DSHS had to ensure it was able to identify, develop, and implement services that were significant enhancements to what the control group could already receive for the pilot to be most likely to have an impact on individuals' outcomes. The primary differences between the pilot and the existing SNAP E&T program were offering a mandatory, upfront job readiness course, work-based learning, and more robust support services. However, less than half of treatment group members started the job readiness course and fewer completed it. Virtually no one started work-based learning, and support services were offered inconsistently across providers. Therefore, many treatment group members did not receive the services or participate in the activities that were the main differentiators between the pilot and the existing SNAP E&T program, which resulted in small differences in overall rates of participation in education or training-related activities between research groups. This suggests that having a robust existing SNAP E&T program, created less room for substantial improvement in take-up and completion of activities through RISE and likely contributed to the lack of impacts.

Discussion of SNAP participation impacts. The findings related to SNAP participation generally make sense given the patterns of changes in earnings for treatment and control group members. Conceptually, SNAP E&T services are designed to increase individuals' earnings and, thus, reduce their need for SNAP or other public assistance. Pilots without an impact on earnings also generally did not show an effect on

SNAP participation. Although impacts on earnings in Mississippi (BCCS) and Virginia did not result in reduced participation in SNAP, it is possible that the increase in earnings partly reduced SNAP benefit amounts as a percentage of the maximum benefit, but the increase in earnings was not large enough to make individuals ineligible to receive SNAP. It is also possible that the increase in earnings did reduce the likelihood of participating in SNAP, but this reduction was offset by some treatment group members being more likely to continue participating in SNAP to remain in the education and training activities provided as part of the treatment group services.

Discussion of costs relative to benefits. With the exception of three pilots (California, Mississippi, and Georgia), the net benefit of the pilots was negative to society. Despite having a positive impact on earnings in California (NS) and Virginia, the increase in earnings was not large enough to offset the costs of the pilot. The seven pilots without an impact on earnings mostly had a negative net benefit as well. The absence of an impact on earnings is one of several reasons why the net benefit was negative, but this primarily reflects the differential costs of treatment group services, which were not offset by the benefits accrued through earnings and fringe benefits during the 36-month follow-up period. When interpreting this finding, it is important to consider that these enhanced services were new and experimental. The purpose of the SNAP E&T pilot was to test new approaches to providing employment or training-related services. Many of the pilots targeted individuals with high barriers to engaging in services and obtaining employment, and some pilots led the development of new partnerships in communities where none existed previously. Even though we excluded the costs of planning and recruitment in considering the cost differential between treatment and control group services, the costs of the former were likely higher for the three years the pilot operated than they would have been if these services had been provided over a longer period of time. In addition, the estimated net benefits reflect the effect of treatment group services for the average treatment group member compared to the average control group member. These averages include all individuals who enrolled, regardless of whether they ultimately participated in services. It is possible that limiting the cost-benefit analysis to individuals who took up services might result in showing the benefits of treatment group services exceeding the costs from all perspectives, even if the costs of services for those who engaged were higher.

I. Future analyses and what SNAP E&T administrators can learn from the pilots

Based on these evaluation findings, there are several options for future analyses to delve more deeply into activity and employment barriers, the effectiveness of specific types of activities, and the effects of the pandemic. They include the following:

- **Learning more about the barriers to starting employment or training-related activities would help identify which case management and support services could promote greater participation in activities.** This information would help program staff adapt the content or delivery of employment or training-related activities in ways that might increase participation and lead to greater impacts. It would be particularly important in pilots that targeted highly barriered populations and focused their program model on specific types of support services, but ultimately did not achieve a meaningful difference in receipt of support services between research groups.
- **Learning more about the barriers to employment that individuals who completed employment or training-related activities faced would enhance our understanding of why their completion in some pilots did not lead to impacts on earnings.** Additional analyses also should explore whether receiving participation certificates, diplomas, degrees, or occupational licenses can affect differentially the prospect of employment for treatment group members.

- **Assessing the effectiveness of activities separately and in different combinations would help identify promising practices for improving outcomes.** Because many treatment group members participated in multiple activities, isolating the effect of a single type of activity would be challenging, however.

Although outcomes for the pilots were mixed, SNAP E&T program administrators can learn from the implementation of all of the pilots. Using information collected from grantees, partners, providers, and individuals who received pilot services, several key lessons emerged across the pilots, including:

- **A longer upfront timeframe for planning and piloting, and a slower roll-out was important for implementing major program changes.** Staff from several pilots did not think it was realistic to develop and start a new program within a year and suggested that if they could start over, they would roll out the pilot more slowly, over several years or do a staggered rollout in some geographic areas before expanding to others.
- **Effective marketing and recruitment required planning and identifying staff with strong skills in conducting outreach.** Staff needed to enroll many more individuals than they typically served, which required extensive outreach and recruitment. Effective marketing and recruitment required planning and identifying staff who had an interest in conducting outreach and the skills to do so effectively.
- **Strategic partnering was important for most pilots, but clear and consistent communication between all organizations was important for managing partnerships.** Most pilots found their partnerships with new organizations beneficial and suggested they would maintain and grow them long after the pilot ended. At the same time, partnering presented challenges, which often related to a lack of clear communication between organizations. Some pilots worked to formalize communication by holding regular meetings with partners and providers and documenting in writing any major decisions or changes to policy.
- **Aligning policies, missions, and cultures across organizations was challenging but critical for serving the SNAP E&T population as intended.** Some grantees brought together a diverse set of partners and providers that came with their own deeply ingrained policies, procedures, and cultures. Some grantees struggled to align each organization's mission for the pilot, which required them to consistently and repeatedly reinforce the pilot policies to create a cohesive package of services that were delivered consistently across providers and locations.
- **Some providers were not prepared to address the extensive barriers that many individuals in the pilot faced.** Some of the pilots formally targeted individuals with barriers, but most providers did not anticipate that individuals would face as many barriers as they did. Although it is not possible to anticipate every potential need, it is important to know the needs, interests, and barriers of the target population and design a program with them in mind.
- **Customizing services to an individuals' needs was important for keeping them engaged.** Grantees found that not everyone needed or wanted the same set of services. For example, grantees and providers often were excited about the level and types of training opportunities they were offering, but many individuals came to the program in crisis and only wanted to find a job to pay their bills. They found it hard to focus on training—which could last for several weeks or months—without a paycheck. Therefore, conducting upfront assessments and designing programs that provide an array of options to meet individuals' specific needs was beneficial.

- **The pilot model may have affected rates of take-up and completion of activities, so being flexible and addressing issues quickly was important.** After implementing the planned models, several of the pilots realized it was not working as planned and was affecting how individuals engaged in activities. As a result, individuals sometimes took up activities at different rates than expected, did not progress through the model as it was originally designed, or left the pilot before completing services.
- **Robust support services, particularly transportation assistance, were key to getting individuals into activities and keeping them engaged.** Despite the importance and wide use of support services, most pilots still faced challenges in helping individuals mitigate significant barriers that the supports could not fully address. These barriers were most often related to transportation and housing.

Although the SNAP E&T pilots have ended, the lessons learned are beneficial for the current SNAP E&T program administrators and providers. As many States are focused on program improvement, by expanding services and forming new partnerships, they likely will encounter many of the same issues that emerged in the pilots. The pilots showed that coordinated outreach and recruitment is important for connecting SNAP E&T participants with services even when intensive services and robust activities are offered. It is also critical that States are able to connect individuals with support services to reduce their barriers to participation. In addition, anticipating the amount of time, effort, and staff needed for coordination and planning when onboarding new partners, understanding the complexity of developing and implementing new activities in the program, and identifying obstacles to take-up rates prior to implementation also can help administrators avoid pitfalls. As challenges are encountered, administrators and providers need to be flexible and make adjustments to resolve these problems and maximize the effectiveness and reach of their programs.

I. Introduction

The Supplemental Nutrition Assistance Program (SNAP) is the primary source of nutrition assistance for many individuals and families with low incomes. SNAP provides monthly benefits to help participants obtain adequate access to food. For some participants, the program also provides work supports through SNAP Employment and Training (E&T) programs designed to help individuals become economically self-sufficient. Although States are required to administer a SNAP E&T program, they have flexibility in designing and determining its services and activities, which can include assessments and support services, and a range of activities, such as job search assistance or training, occupational skills training, and basic education.

Because the design and offerings of SNAP E&T programs vary considerably across States and little research has been conducted on them, information is limited about the most effective approaches to help SNAP participants gain skills and find work. For this reason, as part of the Agricultural Act of 2014, Congress authorized and funded a group of pilot programs to test innovative strategies for connecting SNAP participants with jobs that would increase their incomes and reduce their need for public assistance benefits. In 2015, the U.S. Department of Agriculture's Food and Nutrition Service (FNS) awarded grants for SNAP E&T pilots to 10 States—California, Delaware, Georgia, Illinois, Kansas, Kentucky, Mississippi, Vermont, Virginia, and Washington.[5]

The pilots varied in their target populations, geographic reach, and the number of individuals enrolled. The majority of individuals targeted by the pilots were unemployed or underemployed and faced significant barriers to employment, such as being homeless or having a criminal history or substance use disorder. Some pilots operated Statewide, whereas others operated in select areas of the State, such as counties, community college districts, or local workforce investment areas. Each pilot enrolled 3,000 to 7,000 individuals, for a total of 44,359 individuals across the 10 pilots.

Services are resources provided or administered to individuals, such as assessments, case management, and support services.

Activities are employment or training-related events in which individuals participate, such as job search assistance training, basic education, occupational skills training, or work-based learning.

The SNAP E&T pilots generally expanded the types and amounts of services provided through States' existing SNAP E&T programs.[6] These typically included (1) a comprehensive skills or clinical assessment to determine an individual's work readiness, skills, and barriers to employment; (2) case management services that developed and supported a detailed individualized work and barrier-reduction plan; and (3) support services,[7] such as transportation assistance, housing assistance, and training or work supplies (for example, uniforms, books, clothes, or tools) that helped reduce barriers both to engagement in the pilot and employment. The pilots

[5] SNAP in California is administered by the counties. The FNS grant was awarded to the State SNAP agency and the State oversaw the pilot, but only Fresno County conducted and primarily administered it. We refer to the Fresno pilot as "California."

[6] For simplicity, we refer to the group of services and activities offered by the pilots as "pilot services" in this report; we continue to differentiate them when describing specific sets of services and activities.

[7] Support services are called "participant reimbursements" in the SNAP E&T program; however, for this report, we describe the package of services as support services.

also offered a range of employment or training-related activities, such as independent job search, job readiness training, job search training or assistance, basic education, occupational skills training, and work-based learning opportunities (such as subsidized employment, work experience, internships, and work study).

The activities offered by the pilots were generally more expansive than those offered under existing SNAP E&T programs, which in most States tended to focus on independent job search and job search assistance. Moreover, while the pilots were operating, existing SNAP E&T programs could not fund some of the services and activities the pilots provided, such as substance use disorder counseling, mental health counseling, and subsidized employment.[8]

Congressional funding for the SNAP E&T pilots also included a rigorous longitudinal evaluation of the pilots. The evaluation included four components:

1. An ***implementation analysis*** that documented the context and operations of each pilot
2. A ***participation analysis*** that examined the characteristics, participation levels, and service paths of individuals in the pilots
3. An ***impact analysis*** that identified what works and for whom by examining impacts on employment and earnings; public assistance receipt; and other outcomes, such as food security, health, well-being, and housing
4. A ***cost-benefit analysis*** that estimated the return on each dollar invested in the pilots

The evaluation of each pilot used an experimental research design in which individuals eligible for SNAP E&T who were enrolled in the pilot were randomly assigned into treatment and control groups that were offered differing arrays of services and activities. Treatment group members were eligible for the enhanced set of pilot services developed, and both the treatment and control groups continued to be eligible for any other services available in their communities. Random assignment ensures that any differences in outcomes between the two groups are a result of the enhanced services and not driven by the differences in the baseline characteristics of the individuals assigned to each group. Through random assignment, the treatment and control groups within a pilot were, on average, similar across a range of characteristics at the time they enrolled. They differed only in the services they subsequently were eligible to receive.

This report summarizes findings from final evaluation reports prepared for each of the 10 pilots.[9] It describes the pilots' designs and implementation, the pilot services individuals received, and the effectiveness of those services in improving individuals' outcomes, measured for a three-year period following random assignment. The report also summarizes findings from the cost-benefit analysis, which itemizes specific monetary costs and benefits of pilot services, and assesses whether the benefits of these services were large enough to offset their costs.

The remainder of this report is organized as follows:

[8] The Agriculture Improvement Act of 2018 (P.L. 115-334) made subsidized employment an allowable SNAP E&T component; the final rule published in January 2021 (FNS 2021) permitted States to begin offering it as an E&T component in March 2021.

[9] The final evaluation reports can be accessed at https://www.fns.usda.gov/research-analysis

- Chapter II presents an overview of the data and methodology used to conduct the analyses in the evaluation.
- Chapter III describes the characteristics of the pilots and the individuals who enrolled in them.
- Chapter IV presents a cross-site synthesis of the common lessons learned from planning, implementing, and operating the pilots, including considerations for their sustainability and replicability.
- Chapter V presents findings from the participation analysis, which describes the pilot services that individuals in the treatment groups received.
- Chapter VI describes differences in the services and activities received by the treatment and control groups.
- Chapter VII presents findings from the impact analysis, which describes the impact of the enhanced services on employment, earnings, benefit receipt, and other outcomes.
- Chapter VIII describes the costs of services and activities the treatment group received and compares their costs and benefits from the perspectives of society, participants, and taxpayers.
- Chapter IX offers conclusions.
- Appendices A to D present additional information about the data sources used in the analysis and the client flows and pathways for each pilot. They also present supplementary tables for the exhibits presented in Chapters VI and VII.

II. Data and methodology

In this chapter, we describe the sources of the data we collected for the evaluation. We then discuss how we obtained the data and the types of information each source provided. We also describe the analysis methods used to address the evaluation's research objectives, including which individuals were included in each analysis. Additional details on the data and methodology used are in each of the 10 State-specific final reports and the technical supplement (citation to be added).[10]

A. Data sources

We collected data from a variety of sources to support the evaluation. The specific time periods covered by these data vary across pilots because of differences in data availability and pilot enrollment periods (see Appendix Table A.1).[11]

Baseline registration form. After obtaining consent, pilot intake staff collected baseline information about individuals who enrolled in the pilot (both treatment and control group members). This information included demographic characteristics, employment histories, and receipt of public assistance.

Implementation data. We collected implementation data during three rounds of site visits to each of the 10 pilot States. We collected information about how the pilots were implemented, including challenges pilot staff faced and lessons learned during different periods of operation. The site visits included interviews with staff from the grantee agency, local offices, and providers; structured observations of provider operations; and in-depth interviews and focus groups with treatment group members and employers. We also collected information during technical assistance and monitoring site visits and telephone calls throughout the planning and service delivery periods.

Administrative service use data. Grantees and their partners and providers collected and shared administrative data that documented the types of services and training and education activities they provided to treatment group members and, when applicable, control group members. For each individual enrolled in the pilot, the administrative data included information on service receipt from the date of random assignment through either the last known date of service or the end of the grantee's service period.

Unemployment insurance wage records. We obtained data on employment status and earnings from State unemployment insurance (UI) wage records for each individual in the pilot. Data were collected for two years before the date of random assignment and at least three years after random assignment (for individuals randomly assigned through September 2017) or at least eight quarters after random assignment (for individuals randomly assigned after September 2017). The UI data contained earnings amounts for each quarter, which we also used to construct indicators of quarterly employment status.

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[10] The supplement provides additional information about the analysis approach, including details on the study design, analytic weights, methods for addressing missing data, and the impact estimation approach.

[11] The start of enrollment varied from January to April 2016 across pilots. Although enrollment continued past December 2017 in most pilots, the availability of data required the analyses in the final evaluation reports to include individuals enrolled before 2018. For most pilots and data sets, this approach allowed the evaluation to assess individuals' service receipt and outcomes over a three-year follow-up period after their enrollment.

SNAP administrative data. Grantees provided SNAP administrative caseload data. We used these data to construct measures of receipt of public assistance (receipt of SNAP and Temporary Assistance for Needy Families [TANF]), SNAP and TANF benefit amounts, income, and, for most grantees, Medicaid. We also used these data to characterize individuals' recent history of SNAP participation. Grantees provided monthly data for all individuals in the pilot from one year before random assignment to generally through December 2020.

12- and 36-month follow-up surveys. We conducted telephone surveys about 12 months after random assignment with individuals enrolled in the pilot through December 2017 (18,524 treatment and control group members). We also conducted telephone surveys about 36 months after random assignment for individuals who responded to the 12-month survey (12,100 treatment and control group members completed the 36-month follow-up survey). The 12-month survey asked for information about individuals' receipt of services, participation in education and training activities, employment, and earnings in the 12 months after random assignment. The 36-month survey asked for similar information for the period between the 12- and 36-month surveys. The surveys captured information about all services and employment or training-related activities, regardless of whether they were provided through the pilot; an existing SNAP E&T program; or providers in the community, such as Workforce Innovation and Opportunity Act (WIOA) programs, community colleges, nonprofits, or other organizations.[12]

The surveys also provided data for measures of household food security status, health, well-being, and housing status around the time of the interview. They also complemented the UI wage records and provided more detail on individuals' employment and earnings, including the number of jobs they held over time; the job start and end dates (if applicable); and characteristics of the jobs, such as hours worked per week, weekly earnings, job type, fringe benefits, and occupation.

Cost data. To estimate the costs of the enhanced services provided to the treatment group members, we collected data from cost workbooks completed by grantees and their partners and providers through the end of the grantee service periods. These data were the basis for calculating total costs and describing cost categories, including those for staff, direct services, supplies and equipment, and overhead and operations. In addition, to estimate the total cost of different types of services and activities, we administered a time-use survey to collect data on the percentage of time direct service providers spent on each type of service and activity provided to treatment group members. As described in the technical supplement, we used data from other sources to estimate the costs of control group services and the dollar values of benefits included in the cost-benefit analysis.

B. Analysis methodology

The findings presented in this report are based on a comprehensive set of analyses of implementation, engagement and participation in services and activities, differences in service use between research

[12] The activities measured in the survey included (1) job search assistance or job search training and (2) education and occupational skills training. Job search assistance or job search training activities included those that helped individuals with resume writing, interviewing, and networking. Education and occupational skills training activities included education in the form of adult basic education or General Education Development (GED) courses, English as a second language (ESL) classes, or college courses; occupational skills training programs that prepared individuals for specific occupations; general job skills training programs that helped individuals learn widely applicable job skills and readied them for work; and work-based learning activities, such as paid or unpaid internships and apprenticeships.

groups, impacts, and costs relative to benefits. The numbers of treatment and control group members included in each analysis are presented by pilot in Appendix Table A.2.

Implementation analysis. The purpose of the implementation analysis was to synthesize information across pilot staff and participants to describe the flow of services and how they changed over time, the challenges staff faced, and lessons learned. The analysis relied on data collected through the site visits and from technical assistance and monitoring site visits and calls. Information from focus groups and case studies was also included to provide context; however, it is important to note that we collected these data from small numbers of individuals and employers, and their experiences and opinions are not necessarily representative of the entire treatment group or all employers. We organized these data by topic and interviewee to facilitate analysis by type of respondent (for example, grantee or provider) and, where appropriate, pilot location within the State.

Participation analysis. The participation analysis used administrative service use data provided by providers to summarize treatment group members' engagement and participation in services and activities following random assignment. (Control group members were not included in this analysis.) This analysis is important for understanding how treatment group members progressed through the pilot and the extent to which they received services and participated in activities offered through the pilot. The data measured individuals' receipt of services and participation in activities during the entire service period in which individuals could have been engaged in services (see Appendix Table A.1).

Analysis of differences in service use between treatment and control groups. Understanding differences in service receipt between research groups is important for interpreting impacts of the pilots on outcomes. This analysis statistically compared service receipt and participation in activities among treatment and control group members over the 36 months following random assignment. The analysis was based primarily on 12- and 36-month survey data, which were available for both treatment and control group members randomly assigned through December 2017. We combined the 12- and 36-month survey data to form a single longitudinal data file that described, for each member of the treatment and control groups, the employment-related services and education and training activities in which they participated during the 36-month period following random assignment, including type and duration.

We compared average measures of service receipt and participation in activities for the treatment and control groups. To improve the precision of the estimates, we used regression models that controlled for the demographic and economic characteristics of individuals at the time of random assignment. We weighted all analyses to ensure that the differences were representative of all individuals enrolled in the pilot before the end of 2017. We used t-tests to determine whether differences between treatment and control groups in service receipt and participation in activities were statistically significant.

Analysis of impacts on employment and other outcomes. To estimate how the enhanced services provided to the treatment group affected individuals' outcomes, we compared the average outcomes of the treatment and control groups over the 36 months following random assignment. Outcomes included earnings, SNAP participation, employment, food security, health, well-being, and housing status.[13] Because treatment and control group members' baseline characteristics on average were the same at the time of random assignment (presented in the pilot-specific final evaluation reports), differences in their outcomes after random assignment can be attributed to differences in the services and activities offered to individuals in the two groups. However, to improve the precision of estimates and adjust for small differences in baseline characteristics that arose by chance due to survey nonresponse or missing

[13] Impacts on health, well-being, and housing status are presented in the pilot-specific final reports.

administrative records data, we used regression procedures that controlled for individual characteristics predictive of the primary outcomes. We also applied weights to each observation to help ensure that estimated differences between the treatment and control groups were representative of all individuals enrolled in the pilot in the State. We constructed these weights to reflect the random assignment process and, for analyses based on the survey data, adjust for survey nonresponse bias.

We estimated the impact of the enhanced E&T services on many outcomes, performing statistical tests for each. The likelihood that some estimates will be statistically significant simply by chance increases with the number of estimates tested. To help guard against this problem, known as multiple comparisons bias, we selected two primary (confirmatory) outcomes before analyzing the data: (1) earnings (based on both the UI wage records and survey data) and (2) SNAP participation in the two-year period (Years 2 and 3) after random assignment. We defined the primary outcomes over this period of time because many treatment group members were expected to be engaged in education and training in the first year, which could have reduced their opportunity for employment during that time. In addition, although it is typical to examine longer-term effects of employment and training programs on outcomes by using the most distant time period from when individuals participated in activities, we did not consider Year 3 outcomes among our primary outcomes in isolation due to concerns about the adverse effects of COVID-19 on individuals' outcomes in that year. Our primary outcomes focus on earnings rather than employment as earnings combines both time employed and hourly wages. We consider impacts on employment and other outcomes as exploratory, providing policy-relevant but less rigorous evidence about the effects of the pilots. This information could be valuable for continuous program improvement and identifying potential hypotheses for more rigorous examination in the future.

Cost-benefit analysis. We estimated pilot costs using the "ingredient" approach to build up total cost estimates from all reported direct and in-kind costs. We estimated three groups of costs: (1) the costs of the pilot, including those for planning and developing the pilots, recruiting treatment and control group members, and providing treatment group services, (2) the costs of all services and activities provided to treatment group members through the pilot and the community, and (3) the costs of all services and activities provided to control group members through existing SNAP E&T and the community. For each group, we estimated the total costs, costs by type of service/activity (such as case management or education), and costs per individual.

In the cost-benefit analysis, we compared the benefits treatment group members received—in dollar terms—by examining changes in their earnings and public assistance benefits from participating in the pilot with the costs of the services and activities that were incurred. Benefits were measured using the impact estimates (treatment-control differences in outcomes) and "net" costs were measured using treatment-control differences in the costs of incurred services and activities. We compared costs and benefits from three different perspectives:

Society as a whole experienced the overall effect of the costs and benefits to individuals and government and taxpayers. Costs or benefits to society were the sum of the costs and benefits to individuals and costs to the government and taxpayers. For example, if taxes were a cost to individuals and a benefit to the government and taxpayers, there would be a net neutral (zero) benefit to society.

Individuals enrolled in the pilot could have realized benefits from increased post-program earnings and incurred costs from decreased benefit receipt. Individuals did not incur costs for participating in activities but benefitted from receiving subsidized wages and support services while participating.

Government and taxpayers (meaning everyone other than individuals enrolled in the pilot) paid costs to fund services and could have realized benefits from increased taxes from individuals and decreased benefit receipt and program administration costs.

We estimated a net benefit of the pilot by comparing the difference between total benefits and total costs from each of these perspectives. A negative net benefit is a net cost based on a given perspective.

III. Overview of pilots

In this chapter, we describe key characteristics of the 10 pilots and the individuals who enrolled in them. We also describe key services and activities available to the treatment group relative to what the control group received.

A. Characteristics of the pilots

All of the pilot grants were awarded to State SNAP agencies in March 2015. Most grantees saw the pilots as an opportunity to develop and provide more intensive services than were currently available or fill a gap in existing services by providing them in areas where SNAP E&T was not available. Some used the pilots as an opportunity to expand their SNAP E&T services to align with what they offered in TANF or WIOA programs, whereas others created services that did not exist at all in the pilot areas. New or expanded services and activities could have included offering more intensive case management, additional support services, work-based learning opportunities, or individualized services that were responsive to each SNAP participant's specific needs.

Participation in SNAP E&T was voluntary in 7 of the 10 pilots. Georgia, Illinois, and Mississippi administered mandatory SNAP E&T programs in some or all of the pilot counties (Exhibit III.1). In mandatory E&T programs, individuals enrolled in the pilot were required to participate in E&T activities (through either the pilot or the existing SNAP E&T program) to retain their SNAP benefits. Whether in the treatment or control group, those who did not comply with these requirements were sanctioned—meaning they lost their benefits and were ineligible to participate in SNAP (and the pilot) for a State-determined number of months or until they became compliant.

Most of the pilots operated in selected areas of the State, but Delaware and Vermont operated their pilots statewide (Exhibit III.1). Pilots that did not operate statewide generally targeted regions that were most in need of services, had the largest target populations, or had providers that could readily offer enhanced services. The areas served ranged from 1 county in California to 35 counties in Kansas. Most of the pilots served a mix of urban and rural communities, but pilots in Kentucky and Vermont primarily targeted rural areas.

Pilots primarily targeted SNAP participants who did not meet a Federal exemption from general work requirements and were considered "work registrants."[14] Several pilots targeted a subset of these individuals, such as new work registrants (work registrants in a household recently approved to receive SNAP benefits). Georgia and Mississippi targeted able-bodied adults without dependents (ABAWDs) because these individuals were mandatory participants in both States, and SNAP E&T program services could help them meet their work requirements. Vermont and Washington targeted work registrants who had significant barriers to employment, such as those with long-term unemployment, substance use disorders, mental health disorders, criminal histories, or unstable housing. Finally, Illinois focused on

[14] Work registrants are SNAP participants who have not met any Federal exemptions from SNAP work requirements and are therefore required to register for work. Federal exemptions apply to individuals who are younger than 16 or older than 59, physically or mentally unfit for employment, subject to and complying with work requirements for another program, a caretaker of a dependent child younger than 6 or an incapacitated individual, participating in a drug or alcohol treatment and rehabilitation program, employed at least 30 hours a week, or enrolled at least half time in a recognized school or training program.

work registrants who had low skills or limited work experience and non-work registrants working 30 or more hours per week but needing skill upgrades.

Exhibit III.1. Key characteristics of pilots

Pilot	Program type	Location	Target population
CA	Voluntary	Fresno County	Work registrants
DE	Voluntary	Statewide	New work registrants
GA	Mandatory	9 metropolitan counties[a]	ABAWDs
IL	Mandatory and voluntary[b]	33 counties served by 7 local workforce investment areas	Work registrants who were unemployed or underemployed with low skills or limited work experience, and individuals working 30 or more hours per week needing skill upgrades
KS	Voluntary	35 counties	Work registrants
KY	Voluntary	8 southeastern rural counties	Work registrants
MS	Mandatory	29 counties served by 5 community colleges	ABAWDs
VT	Voluntary	Statewide	New work registrants with barriers, including substance use or mental health disorders, housing instability, or criminal histories
VA	Voluntary	24 localities served by 7 community colleges	Work registrants
WA	Voluntary	4 urban and rural counties	New work registrants who were long-term unemployed, homeless, veterans, noncustodial parents with child support arrears, or had limited English proficiency and barriers to employment

[a]Originally, there were 10 counties, but Georgia stopped enrolling individuals in Cherokee County in January 2017.

[b] Most individuals enrolled in the pilot (in both the treatment and control groups) were mandatory work registrants.

ABAWDs = able-bodied adults without dependents.

These agencies generally contracted with partner organizations to provide support in developing, administering, or monitoring the pilot, and with providers to deliver pilot services for treatment group members. Partners included community-based organizations, leadership councils, or university boards or centers (Exhibit III.2). Providers included organizations offering WIOA programs, employment and occupational skills training in the community (for-profit or not-for-profit), adult basic education, and postsecondary education or training (community colleges).

Exhibit III.2. Key organizations involved in administering the pilots

Pilot	Pilot period	Key partners	Key providers
CA	January 2016 to December 2018	Fresno Department of Social Services	Reading and Beyond, Fresno County Economic Development Corporation
DE	February 2016 to December 2018	None	Career TEAM, Delaware Technical Community College, Eastside Rising, Food Bank of Delaware, KraftHeinz, PolyTech Adult Education
GA	February 2016 to January 2019	Georgia Department of Labor	Three local workforce investment agencies: DeKalb Workforce Services, Atlanta Regional Commission, Coastal Workforce Services
IL	March 2016 to February 2019	Illinois Department of Commerce and Economic Opportunity, Southern Illinois University Center for Workforce Development	24 community-based organizations
KS	January 2016 to March 2019	University of Kansas—Center for Public Partnerships and Research	None
KY	April 2016 to April 2019	Eastern Kentucky Concentrated Employment Program, Jobs for the Future	Kentucky Adult Education, Kentucky Community and Technical College System, community action agencies
MS	March 2016 to February 2019	Mississippi State University National Strategic Planning and Analysis Research Center	East Mississippi Community College, Itawamba Community College, Jones County Junior College, Mississippi Delta Community College, Mississippi Gulf Coast Community College, Jobs for Mississippi Graduates
VT	March 2016 to December 2018	Community action agencies of Vermont	Vermont Division of Vocational Rehabilitation, Vermont Department of Labor, Community College of Vermont, Vermont Association of Business Industry and Rehabilitation
VA	March 2016 to December 2018	None	Virginia Community College System
WA	February 2016 to December 2018	State Board of Community and Technical Colleges	Washington Employment Security Department, Washington Division of Child Support, local workforce development councils, 22 community-based organizations, and three community and technical colleges

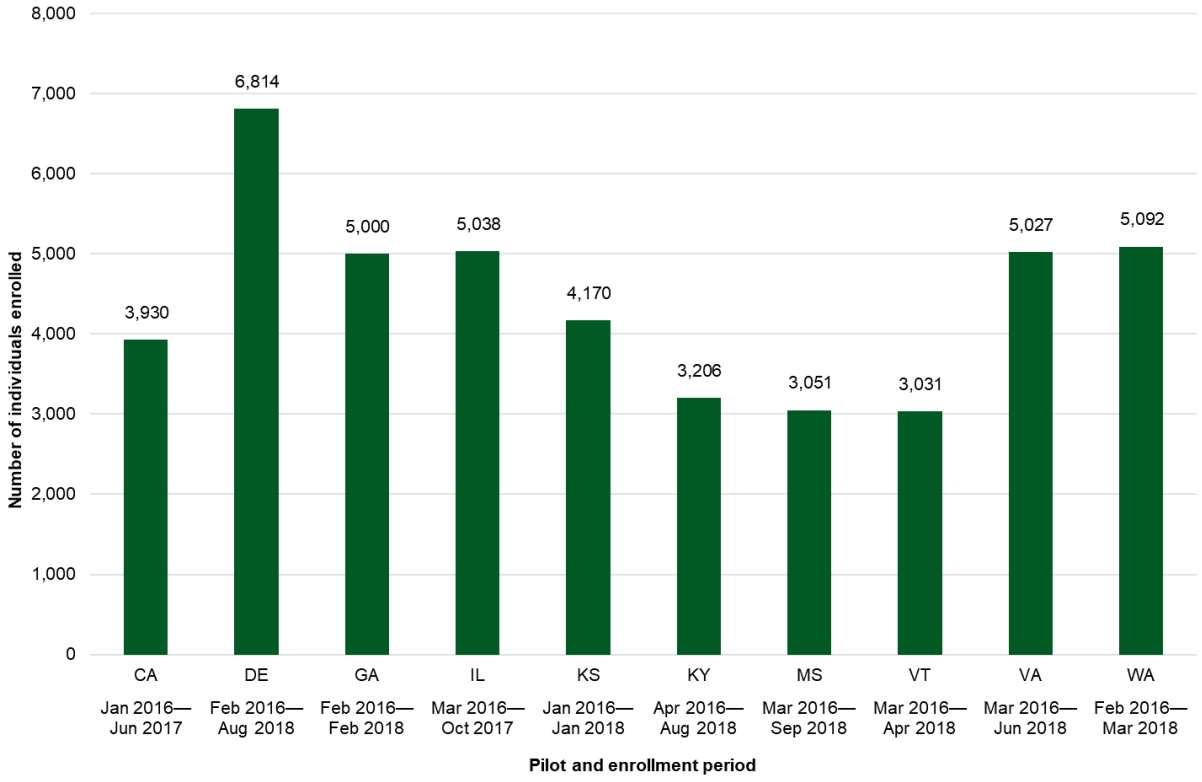
Grantees and their partners and providers began enrolling individuals in the pilots between January and April 2016, depending on the pilot, and pilots provided services for up to three years (ending between December 2018 and April 2019). SNAP participants who enrolled in the pilots were randomly assigned in roughly equivalent numbers to the treatment and control groups, except in California and Mississippi; both of these pilots had three research groups.[15] Pilots enrolled individuals over about a two-year period, but enrollment ranged from 18 months in California to 31 months in Delaware and Mississippi (Exhibit

[15] California assigned individuals to one treatment group and two control groups—a "no services" control group (NS) and an "existing services" control group (ES), but fewer individulas were assigned to the ES than the NS group. Mississipi assigned an equivalent number of indviduals to one control group and two treatment groups—the enhanced community college services (ECCS) group and the basic community college services (BCCS) group.

III.3). Grantees were encouraged to complete enrollment within 18 months, but enrollment periods were extended in almost all pilots to meet enrollment goals.

In all pilots, the number of individuals enrolled increased steadily over time, with most individuals enrolled in 2017. Most pilots enrolled about 4,000 to 5,000 individuals, but enrollment ranged from 3,031 individuals in Vermont to 6,814 individuals in Delaware (Exhibit III.3).

Exhibit III.3. Number of individuals enrolled and timing of enrollment



Source: SNAP E&T random assignment system (January 2016 through September 2018 data)

B. Characteristics of enrolled individuals

Key characteristics of individuals at the time of enrollment (treatment and control group members combined) are summarized in Exhibit III.4. There was considerable variation across pilots, often reflecting the diversity of the populations they targeted. For example, the percentage of individuals who were female varied from 35 percent in Illinois to 74 percent in Virginia, and those living in households with children varied from 3 percent (Mississippi) to 55 percent (Virginia). These percentages largely reflect the types of individuals targeted by the pilots. For example, Georgia and Mississippi both targeted ABAWDs, who frequently are male and not living in households with children; thus, both of these pilots had more individuals living in households without children. There was more consistency in the percentage of individuals who did not have a high school diploma or the equivalent, with most pilots enrolling about 25 percent of individuals with no diploma, and in the average age of the individuals (32 to 39 years old). Across the pilots, few individuals lived in rural areas. Kentucky, which specifically targeted rural areas, was an exception—83 percent of individuals enrolled in Kentucky lived in rural areas. The

percentage of individuals living in rural areas was also higher in the largely rural States of Vermont (37 percent) and Mississippi (20 percent).

In all pilots, most of the individuals who enrolled were not employed at the time of random assignment. The percentage of individuals who reported being currently employed ranged from 5 percent in Mississippi to 28 percent in Virginia. However, many were employed in the two years preceding random assignment (based on UI wage data); 14 percent (Illinois) to 32 percent (Virginia) were consistently employed, meaning they were employed for at least seven out of the preceding eight quarters. In most pilots, more individuals (approximately 35 to 40 percent) were employed in just a few quarters during this period.

Exhibit III.4. Characteristics of individuals at enrollment

Pilots	Female	Average age (yrs)	Without a high school diploma	Living in a household with children	Married or cohabiting	Living in rural area	Currently employed	Never/seldom employed	Sometimes employed	Consistently employed
CA	60%	35	24%	47%	17%	2%	22%	43%	37%	20%
DE	42%	34	24%	19%	7%	5%	12%	35%	42%	22%
GA	48%	33	21%	5%	4%	0%	6%	39%	37%	24%
IL	35%	34	23%	10%	4%	1%	7%	46%	40%	14%
KS	61%	37	23%	42%	14%	10%	16%	31%	39%	30%
KY	59%	33	24%	51%	30%	83%	14%	47%	36%	17%
MS	47%	32	31%	3%	28%	20%	5%	48%	37%	18%
VT	44%	39	19%	14%	11%	37%	14%	44%	37%	20%
VA	74%	37	20%	55%	11%	12%	28%	33%	35%	32%
WA	43%	38	27%	20%	11%	1%	8%	48%	36%	16%

Source: SNAP E&T random assignment system (January 2016 through September 2018 data) and UI wage records

Note: Tabulations include all treatment and control group members who enrolled in the pilot and did not subsequently choose to revoke their consent to participate in the evaluation. “Currently employed” measures employment reported by the individual at the time of enrollment. Based on unemployment wage record data, the terms “consistently employed,” “sometimes employed,” and “never or seldom employed” indicate an individual was employed in at least seven out of eight quarters before enrollment, two to six quarters out of the eight quarters before enrollment, or at most one out of eight quarters before enrollment, respectively.

C. Overview of existing SNAP E&T program and pilot services

After random assignment, individuals assigned to the control group were referred to providers that offered existing SNAP E&T program services; those assigned to the treatment group were referred to providers that offered enhanced services. The referral and service provision approach varied across pilots, but the following sections describe the services generally available to those who enrolled in a pilot. Appendix Table B.1 and Figures B.2 to B.11 provide details on the overall models for each pilot and about the existing SNAP E&T program and pilot services.

1. Existing SNAP E&T programs (control group services)

States that offered an existing SNAP E&T program generally provided a limited set of services (such as case management or support services) and activities (such as training or education programs; Exhibit

III.5). Existing SNAP E&T programs in those pilot States with programs offered some level of case management and support services, but case management often focused on intake and compliance, and support services generally consisted of small transportation payments (about $25 per person per month). Most programs focused on independent or structured job search (job search assistance and job placement) and workfare. Existing SNAP E&T programs in five pilot States—California, Illinois, Kansas, Mississippi, and Washington—also offered education and occupational skills training activities. In general, however, only a small proportion of eligible individuals participated in these activities. Kentucky did not have a SNAP E&T program in any of the pilot counties, and Georgia, Illinois, Kansas, and Virginia did not have programs in some pilot areas before or during the pilots.

2. Pilot services (treatment group services)

FNS did not specify the type of service model grantees needed to develop for the pilots, nor did it require pilots to incorporate specific services or activities into their models.[16] However, FNS encouraged grantees to include innovative strategies that offered activities beyond job search assistance or placement. Grantees had considerable flexibility in designing their pilot models and identifying the services and activities to offer. Some pilots offered different "tracks" of services, which individuals entered based on interests or requirements. For example, Delaware offered three tracks that focused on preparing individuals for jobs in different industries and a fourth track that focused on employment placement; likewise, Virginia offered three tracks to upgrade skills based on individuals' reading levels. Some models required an up-front soft skills or life skills course for some individuals before they could move into other activities (Kansas, Mississippi, and Washington) and/or focused up front on reducing barriers to employment before assigning individuals to activities—a process that could take weeks or even months (Vermont and Washington). Finally, some pilots offered a range of services and activities with no specific pathway, tailoring a package of services to the needs and interests of each individual.

Types of activities

Independent job search: unstructured job search, generally self-directed with minimal assistance

Job search/readiness assistance or training: job readiness workshops, job placement assistance, structured job search assistance, skills-building training (soft skills, interview skills, life skills), job search training

Basic education: basic or remedial education, such as adult basic education, GED or high school equivalency (HSE) preparation instruction, reading or math boost-ups, and ESL

Occupational skills training: short-term occupational or vocational skills training

Work-based learning: employment opportunities to provide individuals with general or specialized work experience that could be paid or unpaid, including subsidized employment, work experience, internships, and work study

Other activities: a range of activities that were not the primary focus of the pilots or that few individuals received, including postsecondary education (for obtaining a degree), financial literacy counseling, and workfare

Services. All of the pilots offered treatment group members more services than were available under existing SNAP E&T programs. Pilots generally offered intensive case management, but its definition varied across pilots. Some pilots required case managers to hold weekly or monthly check-ins with

[16] States are required under law to provide transportation and child care assistance to individuals participating SNAP E&T programs if an absence of these supports would prevent the individual from participating.

individuals; others left decisions about the frequency of contact to case managers' discretion. Most pilots used a centralized approach to providing case management, but Illinois and Washington each had more than 20 service providers, so they allowed providers to determine their own case management approaches. Many pilots used WIOA staff or other provider staff to conduct intakes and check-ins; these organizations used procedures similar to those they used with anyone obtaining services at their organization. However, some grantees revised existing intake and assessment processes to focus more heavily on assessing barriers and implementing strategies to mitigate them, especially when those features were not already a focus of the provider. Other States hired or identified staff who had specialized skills (with a focus on clinical social work or counseling), or trained existing staff to use coaching or mentoring approaches when providing case management. When individuals accessed pilot services from multiple organizations, a few pilots used a team-based approach to coordinate case management across providers.

Although existing SNAP E&T programs offered support services (mainly transportation and child care assistance, which are mandated), the pilots offered more generous and a broader array of support services, including housing, personal care items (such as eyeglasses or dentures), occupational skills training, and work supplies (for example, uniforms, books, clothes, or tools). The support services offered sought to help individuals reduce barriers to employment and support their involvement in activities. Some pilots, such as those in Kentucky, Vermont, and Washington, planned to provide support services to most treatment group members and cover all or most training- or work-related costs. Other pilots, such as those in California and Delaware, planned to provide supports only after individuals had explored all other options to mitigate barriers (such as getting a ride from a friend to a training or trying to find housing with a family member before obtaining assistance from the pilot).

Activities. Although the pilot models differed across the States, the range of activities they offered were similar. Many continued to offer independent job search, but most focused on more structured job search activities such as job search assistance, job readiness training, or job search training. Virtually all pilots included providers that directly offered occupational skills training and basic education or referred those interested in these activities to education or training providers in the community that were not part of the pilot (Exhibit III.5). Eight pilots offered work-based learning placements. Some also offered additional classes or training in soft skills, life skills, financial literacy, and digital literacy.

Exhibit III.5. Key activities offered to treatment group members

Pilot	Job search/ readiness assistance/training	Basic education	Occupational skills training	Work-based learning	Other
CA	✓	✓	⊙	✓	
DE	✓	⊙[a]	✓	✓[b]	Financial literacy counseling
GA	✓		✓	⊙	
IL	✓	✓	✓	✓	
KS	✓		✓		
KY		✓	✓	✓	
MS	✓	✓	✓	✓	Postsecondary education
VT	✓	⊙	⊙	✓	Classes to earn Governor's Career Readiness Certificate
VA	✓	✓	✓		Digital literacy classes
WA	✓	✓⊙[c]	✓⊙[c]	✓	Postsecondary education

Note: Although several pilots offered independent job search, it was not a key feature of the pilots and is excluded from the table.

✓ Activities offered directly through the pilots by pilot providers.

⊙ Referrals for activities made to providers in the community (not provided directly by pilot providers).

[a] Short, online "boost-up" modules were available, but referrals were made to adult education if basic education was needed.

[b] Work-based learning was offered only as part of two of the industry-specific tracks.

[c] Some providers offered this activity directly; others referred individuals to providers in the community.

ECCS = existing community college services treatment group

IV. Key implementation lessons

In this chapter, we present a cross-site synthesis of implementation findings. The information is based on an analysis of qualitative data collected through telephone calls and in-person interviews with pilot staff from State agencies, partners, and providers, as well as focus groups conducted with individuals participating in pilot services.

For most of the pilots, there was a period of 10 to 12 months between the time the grants were awarded and the start of pilot enrollment. During this time, grantees developed new partnerships, created service models, developed new activities, and hired staff for the pilot. The amount of work required during this period was significant, but all grantees were able to begin enrollment with most pilot services in place. Overall, most of the grantees implemented their pilots as intended, making some changes over time in response to emerging needs. Despite this accomplishment, most pilots faced challenges during the planning and implementation periods, and some faced continuing challenges throughout their operation. Grantees often were able to implement changes to their policies or procedures to address these challenges but not always. These challenges, even if mitigated, may have affected how the pilots were implemented and the outcomes of individuals enrolled.

We asked grantee, partner, and provider staff what they learned from planning and implementing the pilots and what they would do differently if given the opportunity to start over. Several key lessons emerged across the pilots, including the following:

1. A longer up-front time frame for planning and piloting, and a slower rollout was important for implementing major program changes.

Almost universally, staff discussed the need for a longer planning period and a slower rollout of the pilots. Most grantees had about a year to plan their pilot, but many were making major changes or creating programs that did not exist previously, which took much longer than anticipated. Staff also faced other challenges during the planning process—some partners or providers stopped participating; developing plans and materials, and creating or revising data systems took more time than anticipated; and finding and hiring qualified staff was challenging. Staff acknowledged the importance of having a planning period that allows staff at all levels and across organizations an opportunity to contribute and share their ideas. However, depending on the number of partners and providers involved, this process can be time consuming. Staff from several pilots did not think it was realistic to develop and start a new program within a year and suggested that, if they could start over, they would roll out the pilot more slowly over several years. Some pilot staff discussed rolling the pilot out in one county or region first and then using what they learned from that experience to adapt implementation in additional counties or regions. Similarly, other pilot staff suggested starting small and expanding only when they had the staff and resources needed to support a realistic level of growth.

Although all of the pilots launched within about a year of their award, some had to delay their start a few times. Other pilots started on schedule but without some procedures, systems, or activities fully in place. In these cases, changes in policies and procedures enacted after the initial start-up often caused confusion among pilot staff and required frequent retraining. Also, some pilots, such as Delaware, Vermont, and Washington, were changing or enhancing their data systems after the pilot began, which required staff to document some aspects of service delivery on paper or in other electronic formats and then later enter this information into a new system. Staff noted that the time they spent dealing with data issues was time they could not dedicate to recruiting individuals to enroll in the pilot or providing case management to

treatment group members. Also, until the new systems were in place, it was difficult for pilot leadership to monitor the pilot and make needed changes to the model.

Staff in many of the pilots reported that they did not have all of the needed staff in place during the planning and early implementation periods. Some staff suggested they felt pressure to launch the pilots, which resulted in making hasty hiring decisions. For example, in Delaware and Kansas, staff emphasized the importance of allowing adequate time for hiring staff who were a good fit for their positions, rather than rushing to bring on staff in the interest of a quick rollout. Staff in both Delaware and Illinois discussed the need to anticipate and prepare for the significant amount of time needed for hiring, training, and retraining due to staff turnover. Staff suggested that having more well-defined job descriptions and planning for a three-month onboarding and training period would have helped.

Even with extensive planning, pilots could find developing and implementing pilot services that did not previously exist particularly challenging. Although many of them were expanding an existing set of services or adding those already being provided to other groups, a few pilots created entirely new services or provided them in areas where a SNAP E&T program had not been available before. These more extensive development processes were challenging and sometimes contributed to delayed implementation. For example, both California and Mississippi developed new work-based learning opportunities, and both pilots struggled to launch these efforts and move treatment group members into the placements. Staff in these pilots faced challenges in finding employers who met the interests and skill sets of the individuals enrolled in the pilot and were willing to hire them. Even when the pilots identified appropriate employers, the process of moving individuals into employment opportunities could be slow because of requirements the individual had to meet to qualify for the positions. Staff suggested that pilots could have addressed these challenges with more up-front planning to determine how these processes would work and solicit more involvement from local workforce agencies that had existing connections to employers. The two pilots with relatively high participation in work-based learning—Illinois and Kentucky—relied on the local workforce agencies to provide the activities and connections to employer networks.

> *"[We] focused on launching things within [the grantee agency], and we tried not to burden partners until we felt confident about forms [and] processes."*
>
> -Delaware grantee staff on explaining their approach to planning the pilot

Delaware also encountered challenges with implementing new occupational skills training programs. For example, one training track brought together a community college and an employer to offer a certification followed by subsidized employment. However, pilot staff had limited communication and coordination with the community college and employer during the planning period, which resulted in issues emerging after implementation that prevented individuals from participating in activities. Staff from all organizations agreed that there should have been more discussion about the details of the service flow and each organization's requirements before the pilot began.

2. Effective marketing and recruitment required planning and identifying staff with strong skills in conducting outreach.

Most pilot staff were not accustomed to recruiting individuals to participate in existing SNAP E&T programs. Generally, these providers serve whoever voluntarily comes through their doors, so staff do not have to seek out participants to fill their programs. For the pilots, staff needed to enroll many more individuals than they typically served, which required extensive outreach and recruitment. Effective

marketing and recruitment required planning and identifying staff who had an interest in conducting outreach and the skills to do so effectively.

Because of the robust services offered through the pilots, many grantees initially thought they would not need to do much recruitment; some did not develop detailed plans for outreach and recruitment before the pilots began. However, after they began enrolling individuals into the pilot, most grantees realized that they had to add resources to their recruitment efforts or change their approach to meet their enrollment goals. For example, after several months of recruiting, Kentucky, Mississippi, and Georgia developed and distributed videos that introduced the pilots and shared success stories, and Delaware and some providers in Washington employed dedicated recruiters to focus solely on recruitment.

Some grantees did not coordinate recruitment or provide a systematic approach for outreach; instead, they let each partner and provider develop an approach and materials that best fit its population. This approach led to disjointed and inconsistent outreach and recruitment efforts across the pilot areas. To address this issue across multiple providers, a few grantees ultimately provided outreach plans, materials, and messaging for all partners and providers to use. These more standardized approaches helped ensure they were reaching SNAP participants across the State and relaying a uniform message. Some pilots recognized the importance of outreach and recruitment at the outset. For example, Kansas hired a professional marketing firm during the planning phase to develop a detailed outreach plan. The firm spent months conducting focus groups and interviews with staff and SNAP participants to test messaging and prototype materials. It then distributed the outreach plan and related materials to all pilot staff and reinforced the messaging and approach during frequent meetings. Other pilots, such as Kentucky, developed outreach materials with consistent messaging that providers could tailor to meet their needs.

Most grantees acknowledged that having an outreach plan in place from the start of the pilot would have benefited them. However, they also recognized that a one-size-fits-all approach for outreach and recruitment would not work. Most grantees created a list of SNAP participants potentially eligible for the pilot and circulated it to partners and providers, who then would make telephone calls and send letters or emails to individuals on the list. However, staff often found that the contact information included in these lists (taken from the SNAP caseload files) was out of date by the time staff started their outreach efforts. Although these lists were a good starting point, staff in all of the pilots realized they needed to do more. Approaches that produced more successful results included conducting home visits or meeting people in the community (as pilot staff in California and Delaware did); placing outreach staff at local SNAP offices (as done in Delaware, Mississippi, and Illinois); and implementing targeted marketing campaigns (ads on the radio, buses, billboards, videos shown in the lobbies of the SNAP agencies and provider organizations, and flyers posted in the community).

Staff also recognized that decisions about who conducted the outreach efforts mattered. Several grantees and providers discussed the importance of ensuring that staff assigned to this role had the necessary interest and skill sets to perform effectively. Some staff did not excel in this role—they were not comfortable being out in the community conducting outreach or cold calling SNAP participants to try to "sell" the program. Many of the staff hired to be case managers were more comfortable working one on one with individuals and not interested in conducting outreach. In addition, it was important to assess whether staff had the capacity to take on multiple roles. For example, in several pilots, case managers were also responsible for recruiting. In some cases, this approach worked well; in others, however, caseworkers struggled to balance their workload. Some caseworkers felt they were not serving treatment group members as well as they could have because their recruitment responsibilities meant they did not have enough time to spend with them. In California, several case managers indicated that their

recruitment duties contributed to job dissatisfaction and turnover. Across most pilots, staff suggested that hiring dedicated recruitment staff with a customer service or sales background would alleviate these issues.

3. Strategic partnering was important for most pilots, but clear and consistent communication between all organizations was important for managing partnerships.

Many pilot staff cited collaboration with partners and providers as one of their major accomplishments but also one of their biggest challenges. Partnerships were important for the pilots because partners and providers performed important functions, such as conducting outreach, providing direct pilot services, and helping to administer or oversee specific aspects of the pilots. Partnering was also important because State SNAP agencies generally did not have the capacity to administer all aspects of the pilots on their own, nor did they want to duplicate services or supports that other organizations in the community could be or already were providing. SNAP eligibility staff did not provide direct pilot services, but some pilots, including Illinois and Mississippi, used eligibility staff to enroll individuals and then refer them to providers for pilot services. In addition, staff in some pilots—such as Kansas, Kentucky, and Vermont—found that the pilot allowed agencies and providers that worked with similar populations to work together successfully in the communities, often for the first time, and share their resources and experiences. Washington pilot staff found that engaging a wide array of partners and providers early in the planning process and distributing the pilot design and development work across them encouraged broad buy-in for the pilot. Moreover, because partner and provider organizations knew the target populations, they were able to support the grantee in developing a pilot that best met the needs of the intended population.

At the same time, partnering brought challenges. Many of the pilots sought to develop partnerships with organizations that had not typically worked with one another or with the SNAP agency in the past. Challenges in building these relationships often related to a lack of clear communication between and across organizations. Some pilots did not consistently engage their partners and providers in planning and decision making, which led to inconsistent service delivery and misunderstandings. In some cases, the use of verbal rather than written communication also led to inconsistent messaging to staff and providers. Communication generally improved after grantees began holding regular meetings with partners and providers, and providing written documentation detailing important changes in policies or procedures. Also, some pilots found that data systems could be used effectively to share information across multiple organizations and help staff stay in contact regarding the treatment group members they served. Two pilots—Kansas and Kentucky—also used collective impact meetings, at which all stakeholders periodically came together to discuss how to implement and improve the pilot, to help ensure that everyone was invested in the pilot and working together toward a common goal.

> *"Discussions between partners can be transformative, but how you talk to each other matters."*
>
> -Kentucky pilot provider staff

In addition, grantee oversight varied across the pilots. Some grantees were very involved, whereas others were more "hands off" and assumed that providers would integrate the pilot policies into their existing programs. However, in the end, most grantees agreed that programs do not run themselves, even when working with providers that have operated such programs for decades. In fact, sometimes long-established providers were especially resistant to implementing different approaches and policies unless they were clear and were consistently reinforced by pilot staff.

To better manage these programs, grantee and provider staff suggested they needed clear lines of communication and inclusion of all organizations early in the process. They also needed to have procedures in place for open dialogue within and between organizations. Often the case managers said they did not feel "heard," and some did not know with whom they should discuss questions or issues. Some providers and case managers also did not feel that they could trust the grantee (or pilot leadership) because relationships had not been built early and throughout the pilot. In addition, in some pilots, the leadership needed to be open to feedback and potential criticism. When pilot leadership was defensive or did not take action, communication broke down.

4. Aligning policies, missions, and cultures across organizations was challenging but critical for serving the SNAP E&T population as intended.

Bringing together a diverse set of partners and providers to serve SNAP participants was not an easy task. Each came with its own deeply ingrained policies, procedures, and cultures that needed to be woven together to serve individuals enrolled in the pilots. Also, teaming with organizations that had not worked together previously required extensive coordination. Organizations often had different approaches to employment and training. Some grantees struggled to align each organization's mission with that of the pilot, which made it difficult to create a cohesive package of pilot services delivered consistently across providers and locations, and standardize policies and processes.

Kentucky faced one of the biggest challenges in aligning organizations because there was no existing SNAP E&T program in the pilot area. Thus, the grantee relied heavily on employment and training providers already working in the area. However, the goals and missions of the various partner and provider organizations sometimes clashed, which made it difficult to weave existing services and activities into a package of services that best fit the needs of those targeted for the pilot. For example, the pilot was focused on providing occupational skills training and work-based learning opportunities, and then helping individuals transition into employment. However, each provider had a slightly different goal, based on its own mission, which created challenges early in the planning and implementation periods. The workforce agencies often aimed to get people into employment quickly, whereas community colleges encouraged individuals to remain in classes for multiple semesters or years (for example, stacking short-term training or continuing on to receive a degree). The grantee staff suggested that they underestimated the time needed to coordinate and develop pilot services within these existing systems.

In other pilots, such as Illinois and Washington, providers not previously involved with SNAP E&T programs discussed their difficulty in understanding SNAP policies, which could be complex. Staff in Illinois said that there was often confusion (even at the State level) about the distinction between ABAWDs and work registrants. Across pilots, workforce staff and other providers also said that SNAP policies did not always align with their own policies and goals. Several key differences in processes and intensity of services existed that required provider staff to shift their mindsets. In Kentucky, managers at some providers noted that those staff hired for the pilot who did not have experience with WIOA policies generally acclimated to the pilot better and were more effective in serving the individuals enrolled. In contrast, those who had worked for a WIOA agency in the past often fell back on what they already knew and did not always consistently apply pilot policies. Some staff suggested that in the future, the SNAP E&T program should hire separate staff to serve SNAP participants so the individuals received the services as intended.

Also, some providers had missions that were inconsistent with serving individuals in a mandatory program. In both Illinois and Mississippi, sanctioning policies and procedures were especially challenging

for provider staff. Providers often wanted to keep trying to engage individuals even when they were not initially responsive and keep cases open when someone left without completing pilot services to see if they would return; mandatory participation requirements did not allow for this approach, however. Providers would have benefited from understanding SNAP policies during the planning and designing period because not all providers were a good fit for the type of SNAP E&T program the State was operating.

5. Some providers were not prepared to address the extensive barriers that many individuals in the pilot faced.

Some of the pilots formally targeted individuals with barriers, but most providers did not anticipate that individuals would face as many barriers as they did. The depth of these barriers was surprising to many providers and often more pervasive than those in the populations they typically served. Although it is not possible to anticipate every potential need, it is important to know the needs, interests, and barriers of the target population and design a program with them in mind. This process can include identifying occupational skills training and employment options that best meet the needs of those who will enter the program, and designing training opportunities that consider that many SNAP participants likely will have criminal background issues or education levels that preclude them from starting and completing training.

Staff in most of the pilots noted that many individuals faced barriers to participating in activities. The most frequently cited barrier was lack of transportation. Others included unstable housing, physical or mental health issues, substance use disorders, and lack of child care. All of these barriers are relatively expensive to resolve, and most communities lack adequate community resources or openings to serve those in need. In several pilots, individuals could not always meet the criteria for participation in an activity, particularly training, including reading or math skills above an 8th to 10th grade level, passing a drug test, and no felony or sexual felony convictions. Also, pilot staff said that transportation issues could interfere with participation if individuals had to travel a long distance to get to a provider, and some had to travel to multiple locations to receive training, support services, and case management.

> *"I don't have a car. I use my parents' car, but there are a lot of us sharing it, and it is not always available when I need it."*
>
> -Individual in California pilot

In Vermont and Washington, individuals worked with case managers immediately after enrolling in the pilot to reduce their barriers to employment before moving on to activities. This effort sometimes took several months of addressing pervasive issues, such as unstable housing or substance use disorders. Vermont also found that developing a "progressive employment" approach that slowly exposed individuals to employment based on their work readiness was useful for individuals facing barriers to employment, such as a criminal history, substance use, or homelessness. The activity was tailored to individuals with multiple barriers to employment because it started with activities requiring a lower commitment, such as an informational interview or job shadowing; and then proceeded to more intensive activities, such as work experience or on-the-job training activities. Staff said this model built confidence and helped clarify job interests among individuals who participated.

Because of the barriers SNAP participants often face, not all providers in a community were a good fit for providing SNAP E&T services. For example, grantees that worked with workforce agencies, such as in Georgia and Kentucky, found that case managers in these agencies generally were not accustomed to nurturing individuals or providing intensive case management services. Some of these staff also questioned why they needed to recruit individuals for the program because they were used to serving people who sought out their services. In Delaware, the pilot approach of working with individuals to keep them engaged in activities, even when they were not meeting expectations, did not align with providers' established policies for absenteeism, which called for expulsion from the training. In Virginia, staff at one community college noted that serving treatment group members required different and more intensive supports than were needed for other students in comparable programs. However, they also pointed out that SNAP participants "had the most to gain" from those programs when they succeeded. Knowing the populations' barriers and interests and clearly communicating them to providers will help administrators learn which providers they need and where there may be gaps in services.

> *"[Individuals need] loving hearts but firm hands."*
>
> -Virginia pilot provider staff on learning to serve disadvantaged populations

6. Customizing services to an individual's needs was important for keeping them engaged.

Conducting assessments with each individual up front was key to determining their needs and matching them with the most appropriate provider. Grantees found that not everyone needed or wanted the same set of pilot services, so providing options that could meet individuals' specific needs was beneficial. They also found it hard to anticipate what would attract individuals to the pilot. Many grantees and providers were excited about the levels and types of training opportunities they were offering, but many treatment group members came to the pilot in crisis and only wanted to find a job and pay their bills. They found it hard to focus on training, which could last for several weeks or months, without a paycheck. Some individuals in the focus groups mentioned that they would have liked to participate in training but were focused on their immediate needs and could not see a way to devote the time needed for training until their situation was more stable.

> *"It's hard around here to just go to school…because you need to stay alive. You have to eat…you can get your education…but what are you going to do in between? How are you going to live?"*
>
> -Individual in Kentucky pilot

Staff also found that some individuals lacked interest in or had different interests than the pilot services being offered. The grantees thus had to pivot to meet the needs of those in the program. For example, in Kansas and Illinois, fewer individuals than expected participated in occupational skills training, but many more than anticipated participated in job readiness skills training because they were interested in moving into the workforce quickly. In some cases, pilots had to reallocate staffing and funds to activities in which individuals were more interested. In Delaware and Virginia, for example, some individuals were not interested in the occupational skills training options because they did not align with their career aspirations. Initially, Georgia had a similar problem because it offered training for only a few in-demand occupations that were not of interest to many individuals in the pilot; eventually, the pilot expanded its offerings to better align with

> *"[Programs should] see where people are, and then see what the program can do for them."*
>
> -Virginia pilot provider

individuals' needs and interests. In Mississippi, Vermont, Virginia, and Washington, individuals were reluctant to participate in basic education or soft-skills training because it delayed them from participating in other activities (such as occupational skills training or work-based learning) or finding employment. To address this issue, some of these pilots allowed individuals to participate in basic education or soft-skills training at the same time they participated in other activities.

7. The pilot model may have affected rates of take-up and completion of activities, so being flexible and addressing issues quickly was important.

After implementing the planned models, several of the pilots realized their model was not working as planned and was affecting how individuals engaged in activities. Reasons for this issue varied across the pilots. In some pilots, the model had multiple "hand-off" points or up-front requirements before individuals could enter employment, education, and training activities. In other cases, the model did not account for the flow of individuals into the pilot versus the timing of activities, which sometimes led to lengthy waiting periods before individuals could start education or training activities. As a result, individuals sometimes took up activities at different rates than expected, did not progress through the model as it was originally designed, or left it before completing activities.

Some of the pilot models faced structural challenges that increased opportunities for exits or limited take-up of substantive activities. These challenges often were related to extended intake processes, including models with orientations that required many steps and visits to multiple organizations or locations. For example, after SNAP agencies in Georgia, Illinois, and Virginia enrolled individuals into the pilot during orientations at their offices, individuals assigned to the treatment group were scheduled for subsequent orientations at a provider location. Significant drop-off occurred between these two types of orientations, and often between the provider orientation and the start of education, training, and employment activities. Other models required individuals to participate in multiweek soft-skills training programs before moving to other activities. Two pilots—those in Mississippi and Washington—designed a model that required individuals to complete a soft-skills training program for four and six weeks, respectively, before moving into education, occupational skills training, or work-based learning activities. Both pilots found that some individuals were not interested in the soft-skills training because they needed to work and could not afford to attend a full-day class for several weeks. This issue sometimes caused individuals to leave the pilot before completing services or to find a job on their own and stop attending classes. In Washington, in particular, the completion rate for the soft-skills classes was much lower than expected; thus, few individuals moved on to education, occupational skills training, and work-based learning opportunities.

> *Often individuals were placed in "filler activities or did busy work" while they waited for college classes to start.*
>
> -Mississippi pilot provider staff

Several pilots also faced challenges in coordinating the flow of individuals into the pilot with the start dates of activities, particularly occupational skills training classes. These classes often were provided through community colleges that offered classes on semester or quarterly schedules, or through other providers that had set schedules for when new classes began or needed to wait for a sufficient number of individuals before starting a new class. Most pilots did not offer occupational skills training on a rolling basis, but the pilots enrolled individuals continuously over a one- to two-year period. Thus, individuals referred to training just after classes began often had to wait until the start of the next scheduled class, which might be a few weeks to months later. Most pilots found that this lag caused some individuals to exit because they were not interested in other available activities or could not afford to go without a paycheck during the waiting period. In other cases, some individuals

waiting for a class to begin would ultimately not participate because they found employment in the meantime or chose to participate in other activities.

8. Robust support services, particularly transportation assistance, were key to getting individuals into activities and keeping them engaged.

All of the pilots offered support services, but the level and availability of these supports varied. Some pilots, such as those in Illinois, Virginia, and Washington, had overall caps on the amount of support services available to an individual; most of the other pilots capped the per-person amounts available for each type of support but not the overall amount across supports. Vermont allowed providers to use their discretion in providing the level of supports each individual needed with relatively few restrictions. Both pilot staff and individuals participating in the pilots (from focus groups) frequently discussed the importance of support services in ensuring individuals could mitigate barriers to participation. In Kentucky, pilot staff and focus group participants described the amount provided for support services and the array of supports offered as unprecedented in their rural communities, and some individuals in the pilot indicated that the transportation assistance (a flat $50 or $200 per month) allowed them to cover their expenses and remain in occupational skills training. They suggested it was difficult to take time away from work for training, but the pilot's supports helped them to do so.

> *"There sure ain't no barriers to getting there, because they make sure you get there. If they have to come pick you up themselves, they will."*
>
> -Individual in Kansas pilot

Some pilot staff underestimated the level of support services needed to mitigate the barriers that individuals faced. Several of the pilots increased the level of support services individuals could receive over the course of the pilot, including Kentucky, Illinois, and Washington. Other pilots tried to identify additional supports they could provide. For example, some community colleges in Mississippi offered free shuttle services to transport individuals from their homes to the colleges for pilot services, and a few pilots offered car repair. Washington began offering cell phones and cell phone minutes to help case managers reach individuals, particularly those who were homeless.

Despite the importance and wide use of support services, most pilots still faced challenges in helping individuals mitigate significant barriers that the supports could not fully address. These barriers were most often related to transportation and housing. The support services often could not help individuals who had no access to a car or public transportation, an issue most prevalent in rural areas. Also, many pilots did not provide assistance for housing or provided too little assistance to resolve housing issues. Availability of shelters or transitional housing was limited in many areas, which further compounded the problem.

V. Participation in pilot services

In this chapter, we summarize the cross-site findings about the pilot services treatment group members received and the employment or training-related activities in which they chose to participate. Using the administrative service use data, we examine overall engagement in the pilot, the types of activities in which individuals participated, the level and frequency of case management services they received, the support services they received, and the timing of and reasons for exiting the pilot.

A. Overall engagement in pilot services

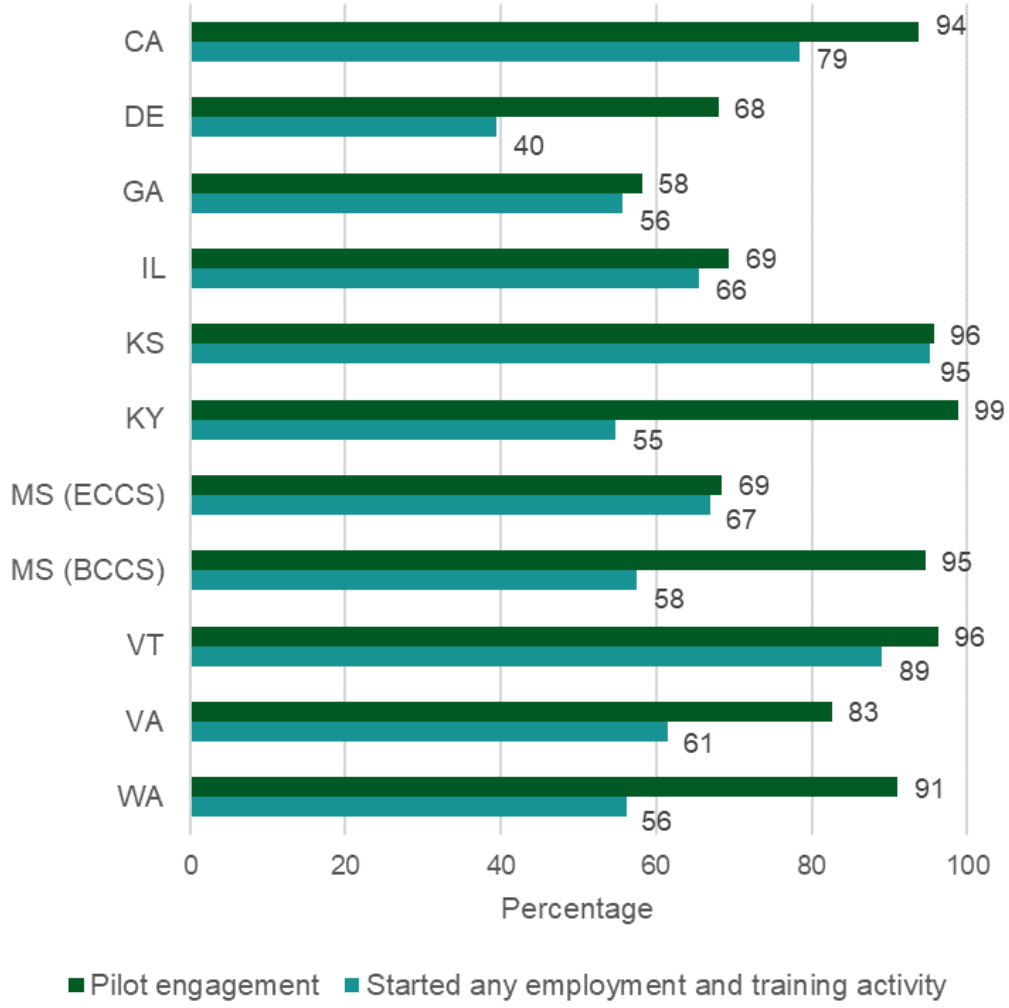
In most pilots, more than 80 percent of the individuals assigned to the treatment group engaged in the pilot, meaning they started pilot intake, assessments, or an employment or training-related activity after random assignment (Exhibit V.1). However, fewer individuals engaged in four pilots: Georgia (58 percent), Delaware (68 percent), and Illinois and Mississippi (ECCS; 69 percent). The lower rates of engagement in these pilots may be due, in part, to the structure of the pilot models—in these pilots, individuals were typically enrolled at a different location from where they subsequently received assessments and pilot services or enrolled and then scheduled for an appointment to come back for assessments and services.

In most pilots, more than 80 percent of individuals engaged in some pilot services, but less than 70 percent started an employment or training-related activity.

In most pilots, treatment group members who engaged in pilot services generally were active for an average of 160 to 250 days, depending on the pilot (not shown); however, there was a wide range—from about 24 days in Georgia to more than a year (449 days) in California. Because California provided 18 months of intensive case management and wraparound services to all individuals in the pilot, this duration is not surprising. In contrast, many of Georgia's pilot services were short term, and almost three-quarters of treatment group members left the pilot within three months of random assignment.

Although initial engagement rates were high in most pilots, the rates at which treatment group members ultimately started an employment or training-related activity after completing intake and assessments were lower (Exhibit V.1). In 7 of the 10 pilots, less than 70 percent of treatment group members started an activity, ranging from a low of 40 percent in Delaware to a high of 67 percent in Mississippi (ECCS). California (79 percent), Kansas (95 percent), and Vermont (89 percent) had higher rates of participation in employment or training-related activities, which may reflect higher participation in job search/readiness assistance or training activities that required a shorter-term commitment than other activities.

Exhibit V.1. Percentage of individuals who engaged in each pilot and started employment or training-related activities



Source: SNAP employment and training evaluation administrative service use data

Note: "Pilot engagement" measures initial engagement in pilot activities, including starting an assessment, developing an individualized career plan, or starting an employment or training-related activity; the measure does not include orientations, case management, and support services because some individuals engaged once to meet with a case manager or receive a support service but then did not return for additional activities and services.

1. Participation in employment or training-related activities

The pilots offered an array of employment or training-related activities that generally fell into one of five categories—(1) independent job search, (2) job search/readiness assistance or training, (3) occupational skills training, (4) basic education, and (5) work-based learning. In four pilots, some individuals participated in all of these activities; in the other six pilots, they participated in all except one activity. The activities most often omitted were independent job search and work-based learning. Six pilots offered other activities that generally were not a primary focus of the pilot or were offered to few individuals—

for example, financial literacy counseling, workfare, and postsecondary education. (These data are not presented in the chapter.)

Exhibit V.2 presents the percentage of treatment group members who participated in each of the five key types of activities. Across the pilots, treatment group members most often participated in job search/readiness assistance or training.[17] In most pilots that offered independent job search, less than one-third of the treatment group members participated; however, more than 50 percent of individuals participated in Georgia, Illinois, and Kansas. About 20 to 30 percent of individuals in most pilots started an occupational skills training activity, but participation was lower in Georgia (6 percent) and higher in Illinois (46 percent). In most pilots, less than 10 percent of treatment group members started basic education, but rates were higher in California (22 percent), Mississippi (BCCS; 16 percent), and Virginia (15 percent). All three of these pilots focused on basic education—California added in-house GED preparation classes, Mississippi's adult basic education services were co-located at the community colleges where all other services were provided, and Virginia designated one of three tracks to basic education. Eight pilots offered some type of work-based learning, such as subsidized employment, work experience, internships, or work study, but in most, less than 15 percent of individuals participated; in Georgia and Washington, participation was less than 1 percent. Illinois and Kentucky were exceptions; in these pilots, 30 and 38 percent of treatment group members, respectively, participated in work-based learning.

Job search/readiness assistance or training had the highest take-up rates across pilots—60 percent or more of individuals in several pilots. Fewer individuals participated in the other activities, usually less than 25 percent.

Overall, individuals who started activities tended to complete at least one (ranging from 53 percent in Vermont to 100 percent in Georgia [not shown]). Completion rates by activity were highest for independent job search and job search/readiness assistance or training (with several pilots having completion rates between 65 to 100 percent). These activities often could be completed quickly, so the higher completion rates could be related to the shorter time commitment required. Completion rates were somewhat lower for occupational skills training—generally about 60 to 70 percent completed—but as few as 35 percent completed in Kentucky and as many as 90 percent completed it in Virginia. In seven pilots, less than 40 percent of those who started basic education completed it. In contrast, in all but one pilot that offered work-based learning, more than 60 percent of individuals who started the activity completed it, ranging from 43 percent in Illinois to 90 percent in Delaware.

[17] In Kansas, Mississippi's ECCS group, and Washington, individuals most frequently started an up-front soft-skills or life skills training course that we included in the job search/readiness assistance or training category.

Exhibit V.2. Percentage of treatment group members who started activities

Pilot	Independent job search	Job search/readiness assistance	Occupational skills training	Basic education	Work-based learning	Other[a]
CA	[b]	71.7	32.3	21.7	4.9	[b]
DE	[b]	32.5	12.7	5.3	3.7	7.4
GA	50.5	49.3	5.5	1.2	0.4	[b]
IL	57.1	29.2	45.8	12.0	30.1	36.8
KS	62.8	70.5	23.2	5.7	[b]	40.2
KY	8.9	[b]	26.9	4.0	38.4	[b]
MS (ECCS)	12.2	61.1	24.4	9.9	15.9	6.7
MS (BCCS)	12.5	15.5	26.9	16.0	13.0	5.4
VT	[b]	85.6	28.5	2.2	8.0	6.3
VA	31.3	53.5	17.8	14.5	[b]	[b]
WA	13.6	45.6	14.6[c]	7.3	0.5	5.2

Source: SNAP employment and training evaluation administrative service use data

[a]Other activities included job retention services, postsecondary education (for obtaining a degree), financial literacy counseling, digital literacy, and workfare.

[b]Indicates the activity was not offered.

[c]Because of the way in which data were provided, occupational skills training in Washington also includes postsecondary education. These values could not be separated; however, most Washington treatment group members participated in occupational skills training.

2. Credentials and certifications

Few treatment group members obtained an occupational skills training credential or certification (not shown). Less than one-quarter of treatment group members in each pilot received a credential or certification,[18] ranging from less than 1 percent in Washington to 21 percent in Illinois. In five pilots, 10 percent or fewer treatment group members earned a credential or certification.

Less than one-quarter of treatment group members earned a certification or credential. They were most frequently earned for training in the medical field.

Among the pilots that reported the types of credentials or certifications earned most frequently, there was a mix of occupations.[19] Training in the medical field (including certified nursing assistant, phlebotomy, and first aid) appeared in the top five types of credentials or certifications earned in nearly all pilots. Other credentials individuals frequently earned were for construction (welding, forklift operations, ironworking), administrative office skills and medical billing, manufacturing, culinary arts, auto mechanics, and commercial driver's licenses.

[18] Kansas could not provide data on receipt of credentials or certifications.
[19] Illinois could not provide data on the types of credentials or certification earned.

B. Receipt of case management

In each of the nine pilots with available case management data, the majority (70 to 100 percent) of treatment group members had at least some contact with a case manager (Exhibit V.3).[20] In seven of the pilots, contact was almost universal; more than 90 percent of the treatment group had at least one contact with a case manager. This situation was due largely to most individuals engaging with case managers immediately or shortly after random assignment.

Most treatment group members received case management, but the average number of contacts varied widely—from 6 to 44 while in the pilot.

Although initial contact was high in most pilots, the average number of contacts per person provides insights into the frequency of contact with a case manager. In the eight pilots with case management contact data (all but Kansas and Vermont), the frequency of contact varied widely. Among individuals who had some contact with case managers while in the pilot, the average number of total contacts per person ranged from 6 in Mississippi to 44 in California, where the pilot generally provided case management for up to 18 months.

Individuals were engaged in the pilots for different amounts of time, so the overall average number of contacts with case managers does not fully measure the level of contact because it depends on the length of engagement. Instead, the average number of contacts per month is a better measure of the amount of case management received. In five of the eight pilots with case management and contact data, individuals in the treatment group had one to two contacts per month with case managers (Exhibit V.3). The average number of contacts per month were higher in California (three), Washington (four), and Delaware (eight). Individuals in California had more contacts overall, but those in Delaware had the most contact with their case managers each month they were in the pilot.

Case managers used multiple contact methods, but in most pilots contact by telephone was most frequent. Between 35 and 50 precent of contacts were by telephone, but in-person contacts were more common in three pilots—Illinois, Kentucky, and Mississippi. In Kentucky, virtually all contacts (99 percent) were in person. Most individuals received transportation assistance, which the pilot provided monthly through a check they collected in person; at this time, they generally checked in with their case manager. A few pilots also relied heavily on electronic communication, such as email, texting, or social media, to reach individuals; 39 percent of contacts in California, 26 percent in Delaware, and 19 percent in Georgia were electronic.

[20] Kansas could not provide data on case management.

Exhibit V.3. Description of contacts with case managers among treatment group members

Contact	CA	DE	GA	IL	KY	MS (ECCS)	MS (BCCS)	VT	VA	WA
Any contact (%)	96.8	99.9	92.5	98.5	96.8	69.5	75.8	86.6	94	93.5
Among those with contact (#):										
Average number of contacts per person	44.0	35.6	15.1	12.5	12.7	5.6	5.9	NA	8.8	22.7[a]
Average number of contacts per person per month	3.2	8.1	1.3	1.0	0.7	1.6	1.7	NA	0.7	3.8[a]
Type of contact (%)										
In person	23.9	18.2	17.7	35.7	99.2	49.4	56.5	NA	28	37.9[a]
Telephone	35.6	42.1	38.4	25.7	0.8	44.0	37.4	NA	42.9	50.0
Electronic: email, text, social media	39.1	25.5	18.8	11.6	0.1	4.8	4.2	NA	12.3	12.0
Mail	1.4	14.0	23.9	26.6				NA	16.7	
Sample size	**1,797**	**3,391**	**200[b]**	**200[b]**	**1,598**	**1,015**	**1,006**	**1,510**	**200[b]**	**2,548**

Source: SNAP employment and training evaluation administrative service use data

Notes: NA indicates that the grantee nor provider were able to provide the data. Data in this table represent all contacts that case managers documented between themselves and treatment group members. Kansas is not included in the table because it could not provide data on case management.

[a]Washington did not capture contact data until later in the pilot period, so these are not comprehensive for all individuals.

[b]The pilot tracked the frequency and type of contacts only through narrative case notes. The evaluation team coded electronic case notes for a randomly selected sample of treatment group members to analyze the frequency and type of contacts.

C. Receipt of support services

Existing SNAP E&T programs offered support services (transportation and child care assistance are Federally mandated) to reduce those barriers individuals faced that could limit their ability to participate in services and find employment. However, the pilots generally offered more generous and a wider variety of support services. In most pilots (8 of 10), more than half of individuals in the treatment group received some type of support service (Exhibit V.4).[21] However, as with other measures of service receipt, there was substantial variation across the pilots, ranging from 25 percent in Georgia to 90 percent in Mississippi's ECCS group.

Generally 50 to 80 percent of treatment group members received a support service while in the pilot, most commonly transportation assistance.

Transportation assistance was the most common support provided. In most of the pilots, almost all of the individuals who received a support service received transportation assistance. The prevalence of transportation assistance was lower in California (23 percent), where individuals were eligible for support services only

[21] According to the available data, only 25 percent of treatment group members in Georgia received support services. This percentage is likely an underestimate because both the SNAP agency and the provider offered support services. However, only data from the provider were available.

if they completed a job readiness workshop series.[22] The pilot also required them to explain how the expense was directly related to obtaining or retaining employment and how they had already tried to find funding for it.

The pilots also offered a range of support services that covered expenses related to occupational skills training, clothing for interviews or employment, and work supports (such as tools or equipment, scrubs, or work shoes). As few as 7 percent of individuals in Illinois received employment, education, or training supplies, whereas as many as 59 percent of individuals in Vermont received at least one of these support services. Several pilots also offered a range of other support services (not shown), such as child care, housing assistance, and medical assistance (for example, dentures, eyeglasses, hygiene packages, and mental health or substance use treatment).

In most pilots, treatment group members who received a support service generally received it for an average of two to four months (not necessarily consecutive months; data not shown). However, treatment group members in California and Kentucky received support services for an average of six and eight months, respectively. All of the pilots provided transportation assistance and employment, education, or training supplies for the longest period of time—up to eight and five months, respectively. Although most other support services generally were provided for just one or two months, Delaware and Kentucky provided assistance with child care costs for an average of four and nine months, respectively.

Exhibit V.4. Percentage of individuals who received any support service and each type of available support service

Pilot	Any support service	Transportation	Employment, education, and training supplies
CA	44.7	22.5	42.9
DE	58.4	56.2	11.4
GA	25.3	13.6	12.2
IL	57.4	56.1	7.4
KS	78.9	[a]	[a]
KY	76.9	73.6	48.2
MS (BCCS)	84.7	83.9	20.4
MS (ECCS)	89.9	89.8	28.1
VT	70.4	49.1	58.8
VA	49.5	48.4	14.6
WA	63.1	57.8	34.1

Source: SNAP employment and training evaluation administrative service use data

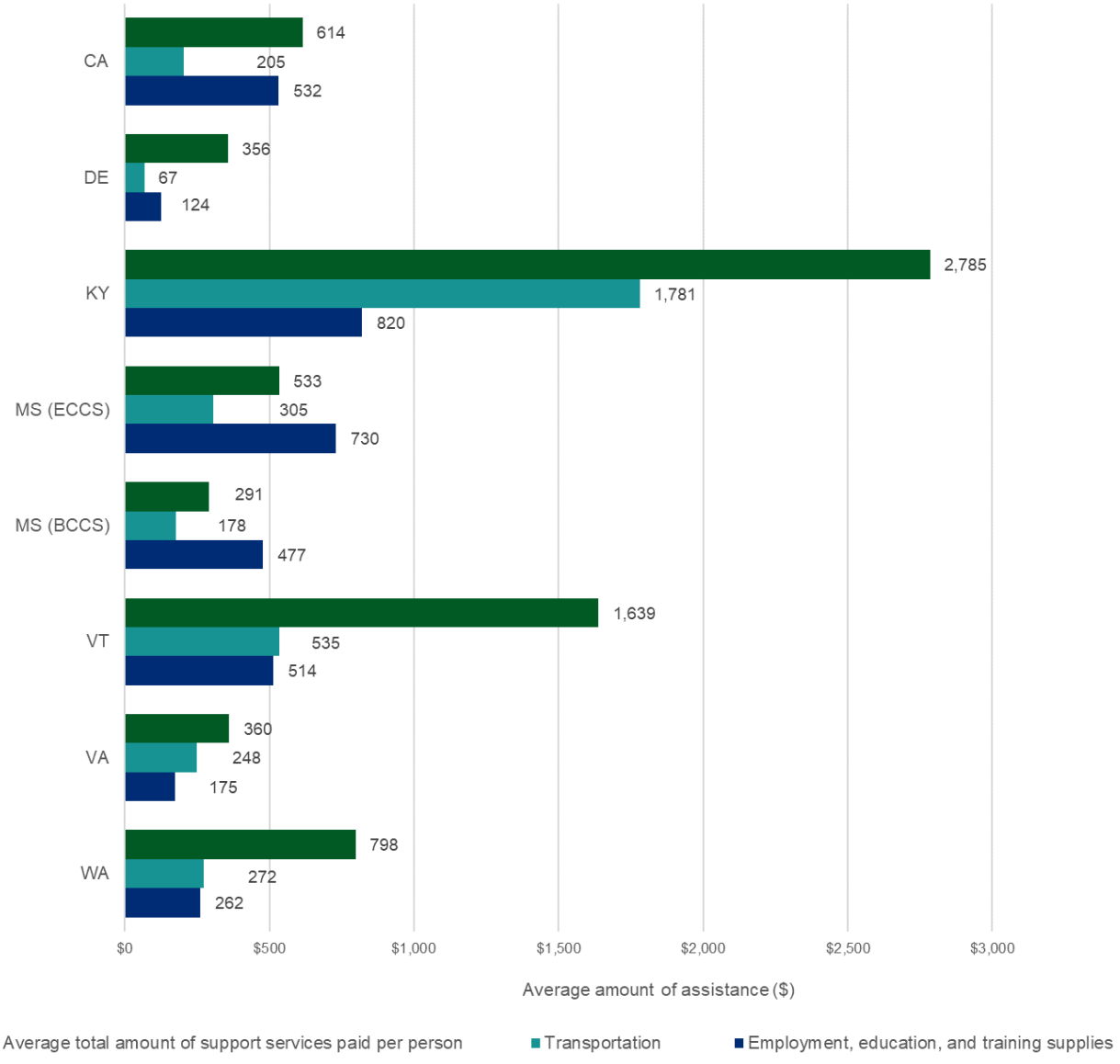
[a] Kansas was unable to provide data for receipt of support service by type.

Among individuals who received some type of support service, the average total value of support services received ranged from $291 in Mississippi's BCCS group to $2,785 in Kentucky (Exhibit V.5). Most pilots provided an average of about $300 to $800 in support services. Among treatment group members

[22] For existing SNAP E&T programs, Federal regulations require States to provide or reimburse individuals for expenses that are reasonably necessary and directly related to participation in a SNAP E&T program, including transportation assistance to physical locations. Conditional requirements on receipt of assistance are not permitted.

who received transportation assistance, the average total dollar value of the support service provided per person ranged widely, from $67 in Delaware (where provision of weekly bus passes was common) to $1,781 in Kentucky (where individuals received either $50 or $200 payments per month for transportation in very rural areas). The amount of assistance with employment, education, or training supplies in most pilots ranged between $450 to $850. Few pilots provided child care or housing, but those often were the costliest support service provided—the average total cost of housing support was $1,680 in Vermont and $983 in Washington, and the average total cost of child care support was $2,869 in Delaware and $3,162 in Kentucky (not shown).

Exhibit V.5. Average amount of all support services and each type of support service received (in dollars), among those who received support services



Source: SNAP employment and training evaluation administrative service use data

Note: Georgia, Illinois, and Kansas could not provide data on the value of support services and thus are not included in the exhibit.

D. Pilot exits

In six pilots, 50 to 80 percent of individuals exited by month six; in the other four, individuals remained in the pilot much longer.

In each pilot, staff documented when individuals exited the pilot and for what reasons. Each pilot defined the reasons for exits, but generally they fell into four primary categories, the individual: (1) successfully completed assigned pilot services; (2) found employment and left the pilot; (3) left before completing assigned pilot services, which could include those notifying the staff they were leaving or those no longer showing up and whom staff were unable to contact; and (4) became ineligible for SNAP or the pilot, which could include someone being sanctioned and losing SNAP benefits, not completing the SNAP recertification process each year, becoming eligible for TANF benefits, or moving out of the pilot area. In addition, there were some individuals who may have still been engaged in activities when the pilot ended. Because they neither completed activities nor chose to leave, we put these individuals into a separate category when possible. Individuals most often left the pilot before completing services (generally 35 to 65 percent) or became ineligible for the pilot (generally 25 to 50 percent of individuals; Exhibit V.6). Fewer individuals exited the pilot because of completing all of the pilot activities (from less than 1 percent in Georgia and Illinois to 46 percent in California) or because they found employment (from 8 percent in Washington to 24 percent in Georgia and Illinois). About 10 percent or fewer individuals were still active in five of the six pilots that tracked this reason for exit, but as many as 23 percent were still active in the Kentucky pilot when it ended in 2019.

Exhibit V.6. Percentage of individuals who exited, by reason

Reason for exit	CA	DE	GA	IL	KS	KY	VT	VA	WA
Completed	45.5	31.1	0.3	0.8	[b]	[b]	35.5	7.6	15.7
Left for employment	[b]	[b]	21.9	24.2	24.2	13.1		8.5	8.1
Left before completing[a]	38.0	61.5	45.8	38.2	43.2	63.8	34.9	46.6	65.7
Became ineligible for SNAP or pilot	16.6	3.7	26.3	26.8	17.2	[b]	29.6	1.0	2.5
Still active in pilot when it ended	[b]	[b]	3.9	10.0	6.9	23.0	[b]	9.0	8.0
Other[c]	[b]	3.7	1.7	[b]	8.5	[b]	[b]	27.3	[b]

Source: SNAP employment and training evaluation administrative service use data

Note: Mississippi could not provide reasons for exit and thus is not included in the table.

[a]Includes individuals who never attended provider orientations in Georgia (30.6 percent), Illinois (25.5 percent), and Virginia (11.9 percent).

[b]The pilot did not monitor or record this reason for exit.

[c]Other reasons for exit include those not specified by the pilot staff in Delaware and those cases with no reason coded in Georgia, Kansas, and Virginia.

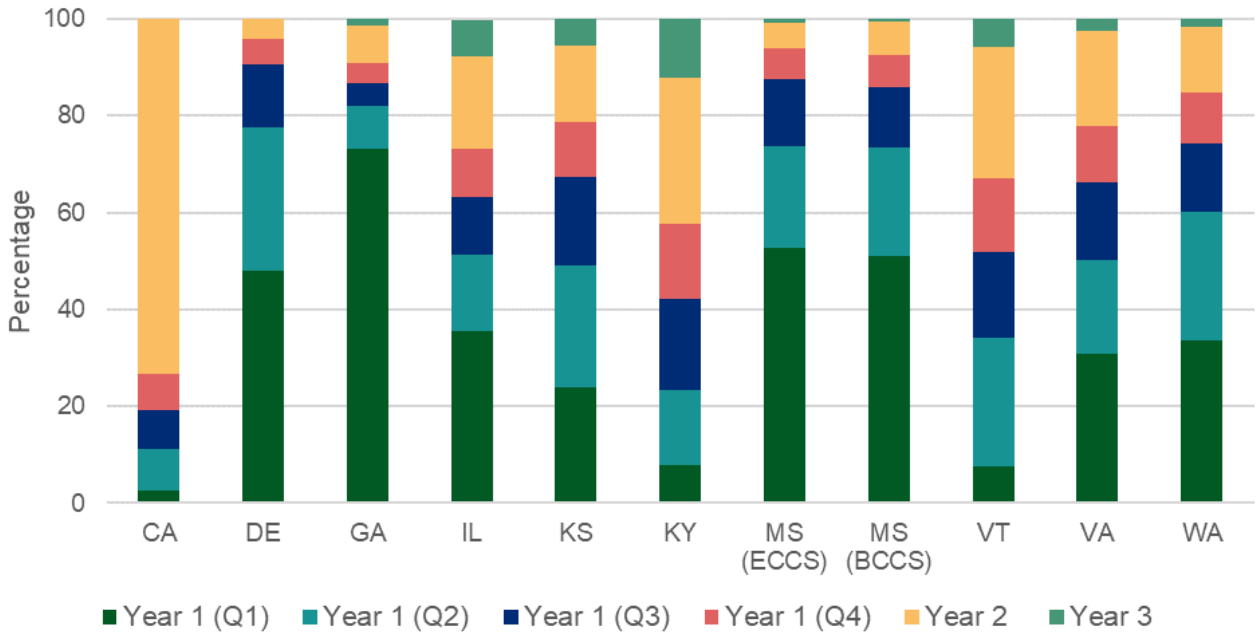
In six pilots, 30 percent or more of treatment group members exited the pilot within the first quarter (three months) after random assignment (Exhibit V.7). Georgia had the highest rate of exit during this period (73 percent). Four pilots—California, Kansas, Kentucky, and Vermont—had lower rates of exit during the first three months, ranging from 3 percent in California to 24 percent in Kansas, and individuals generally remained in these pilots for longer periods of time. In fact, at 12 months after random assignment, 73 percent of individuals in California were still participating in pilot services, likely due to the model—California provided pilot services for 18 months. In Kentucky and Vermont, more than 30 percent of

individuals were still in the pilot at the end of the first year. In the other pilots, 50 to 80 percent of individuals exited at some point before their seventh month after random assignment.

In all of the pilots, most or all individuals exited by the end of the second year after random assignment. Generally, only a small percentage exited in Year 3, but in Kentucky, 12 percent of individuals did not exit until their third year in the pilot. Regardless of when individuals first exited the pilot, they had the option to return and continue participating in services. However, in six pilots, fewer than 15 percent of individuals re-entered the pilot and re-engaged in activities (not shown). In Georgia, Illinois, and Kansas, a larger percentage—about 30 to 45 percent of individuals—re-entered the pilot after their initial exit. These individuals may have re-engaged in activities and subsequently completed them or found employment before a later exit.

Findings on the timing of pilot exits suggest that, in the majority of pilots, many treatment group members left after a short period of time, which limited their access to pilot services. However, as described above, treatment group members left the pilot for a variety of reasons. Whether the timing or pilot exits influenced pilot impacts depends not on the experiences of the treatment group alone, but on the contrast between treatment and control groups in their receipt of services and participation in activities, as well as the length of that participation (see Chapter VI).

Exhibit V.7. Percentage of individuals who exited over time



Source: SNAP employment and training evaluation administrative service use data

VI. Differences in participation in activities and service receipt for the treatment and control groups

In this chapter, we describe how treatment and control group members differed in their participation in activities and receipt of services available through the pilots, existing SNAP E&T programs, or other services and programs available in their communities. Understanding differences in participation and service receipt between the research groups is important for interpreting findings about the impacts of the pilots on outcomes—impacts are unlikely to occur without a meaningful difference in participation and service receipt between the treatment and control groups.

A. Differences between research groups in participation in activities

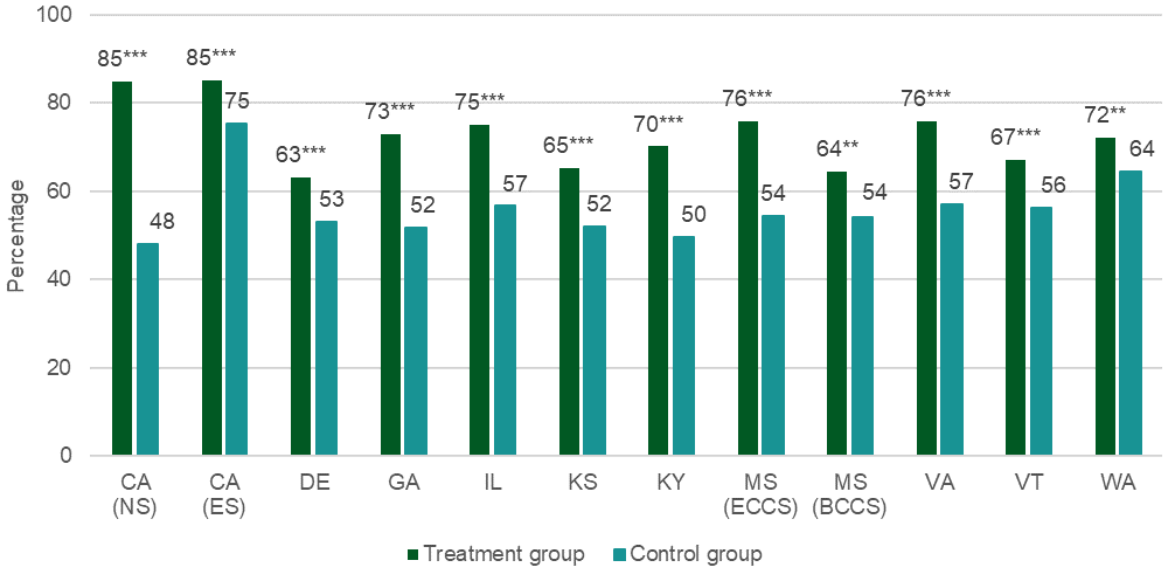
The percentages of treatment and control group members who participated in a job search training or assistance activity or education or training activity are presented in Exhibit VI.1. In each pilot, many control group members who were not eligible for pilot services participated in activities through existing SNAP E&T programs or other programs available in their communities, ranging from 48 percent for California's NS control group to 75 percent for that State's ES control group. In most pilots, control group members were most likely to participate in job search training or assistance activities, but many participated in education and training programs as well (Appendix Table C.1).

Across all pilots, the treatment group was more likely than the control group to participate in an activity.

Across all pilots, treatment group members were more likely than those in the control group to participate in any job search training or assistance activity or education or training activity within the 36-month follow-up period following random assignment (Exhibit VI.1). Differences between research groups were statistically significant in all pilots, but the magnitude of the differences varied. For example, in California, 85 percent of treatment group members participated in activities, compared with 48 percent of the NS control group, resulting in a 37 percentage point difference. In contrast, the difference between treatment and control groups in Washington was 8 percentage points (72 versus 64 percent).

Across all pilots, differences between the treatment and control groups in participation in activities were largest in the first year after random assignment and decreased over time (Appendix Table C.2). For example, in Virginia, there was a 24 percentage point difference between the treatment and control groups in the percentage of individuals who participated in activities in Year 1 following random assignment (69 versus 45 percent). In Years 2 and 3, this difference decreased to 2 percentage points (35 versus 33 percent). In most pilots, the difference between treatment and control groups decreased by 12 to 28 percentage points between Year 1 and Years 2 and 3.

Exhibit VI.1. Percentage of treatment and control group members who participated in any pilot, existing SNAP E&T, or community-offered activities



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(CA (NS) $p < 0.001$, CA (ES) $p = 0.006$, DE $p = 0.001$, GA $p < 0.001$, IL $p < 0.001$, KS $p < 0.001$, KY $p < 0.001$, MS (ECCS) $p < 0.001$, MS (BCCS) $p = 0.029$, VA $p < 0.001$, VT $p = 0.005$, WA $p = 0.018$)

B. Differences in participation in specific types of activities

Section A described the overall difference between treatment and control groups in participation in any activity. We found a similar pattern of results when examining participation in two specific types of activities: (1) job search assistance or job search training and (2) education or training (Appendix Table C.1). Overall, treatment group members were more likely than control group members to participate in both types of activities.

In all pilots except Mississippi (BCCS), treatment group members were more likely than control group members to participate in job search assistance or job search training activities. The magnitude of the differences varied, ranging from 9 percentage points in California (ES; 74 versus 67 percent) and Vermont (56 versus 47 percent) to 47 percent in California (NS; 74 versus 27 percent).

Treatment group members were also more likely than control group members to complete most of the four types of education or training activities: (1) education in the form of adult basic education or GED courses, ESL classes, or college courses; (2) occupational skills training programs that prepared individuals for specific occupations; (3) general job skills training programs that helped individuals learn widely applicable job skills and readied them for work; and (4) work-based learning activities, such as paid or unpaid internships and apprenticeships. Differences were largest for participation in general job skills training (ranging from 6 to 27 percentage points), which encompassed job readiness activities

(Exhibit VI.2; Appendix Table C.3). The differences between research groups in occupational skills training participation typically were larger than for education programs. Across the pilots, differences between research groups in participation in occupational skills training ranged from 3 to 26 percentage points, whereas differences for education programs ranged from -1 to 20 points. Only a few pilots had statistically significant differences between research groups in work-based learning participation; these differences were small (less than 1 percentage point) and there was little, if any, control group participation in such activities in most pilots.

Exhibit VI.2. Percentage of treatment and control group members who participated in specific types of activities offered through the pilot, existing SNAP E&T programs, or the community

Pilot	Treatment group participated in activity	Control group participated in activity	Treatment–control difference	Treatment group participated in activity	Control group participated in activity	Treatment–control difference
	General job skills training			Occupational skills training		
CA (NS)	42.3	15.6	26.7***	41.8	23.3	18.5***
CA (ES)	42.2	29.6	12.6***	41.8	36.2	5.6
DE	24.7	13.7	11.0***	23.5	18.2	5.3**
GA	22.1	15.8	6.3***	25.8	17.8	8.0***
IL	37.3	22.2	15.1***	36.1	20.5	15.6***
KS	23.7	17.5	6.2**	27.5	17.7	9.8***
KY	33.3	16.4	16.9***	35.9	25.2	10.7***
MS (ECCS)	41.8	17.8	24.1***	43.9	17.6	26.2***
MS (BCCS)	33.5	17.1	16.4***	34.9	17.4	17.5***
VA	43.6	21.8	21.8***	49.6	31.0	18.6***
VT	28.7	15.7	13.1***	29.6	15.6	14.0***
WA	43.7	32.1	11.6***	35.1	32.1	3.0
	Education			Work-based learning		
CA (NS)	36.1	17.0	19.1***	0.3	0.3	0.0
CA (ES)	36.1	23.4	12.7***	0.3	0.7	-0.4
DE	15.1	15.8	-0.8	0.9	0.0	0.9***
GA	18.6	13.1	5.5***	0.2	0.0	0.2*
IL	21.5	13.4	8.2***	0.8	0.3	0.5
KS	20.2	17.7	2.5	0.1	0.0	0.1
KY	34.6	21.5	13.1***	0.5	0.0	0.5**
MS (ECCS)	35.6	15.4	20.2***	1.0	0.0	1.0**
MS (BCCS)	28.6	15.7	12.9***	0.1	0.0	0.1
VA	28.3	20.8	7.5***	0.6	0.1	0.5*
VT	24.6	10.9	13.7***	0.2	0.2	0.0
WA	24.6	22.6	2.0	0.3	0.4	-0.1

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

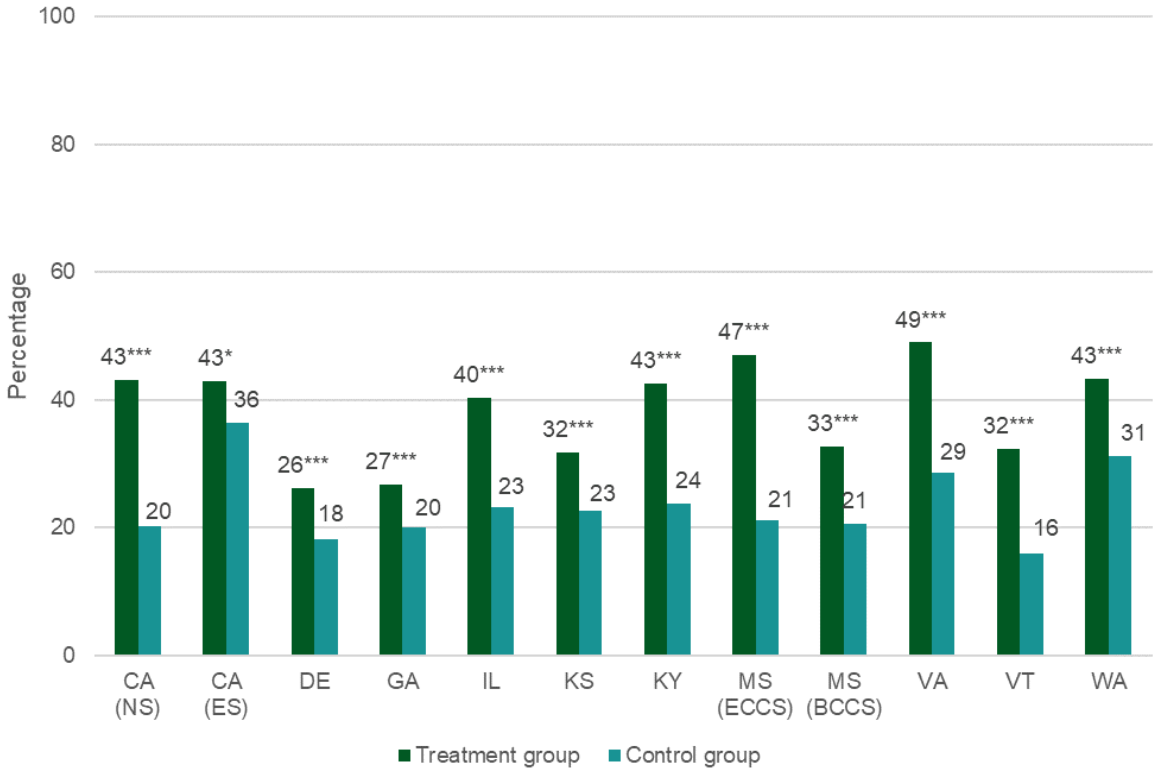
BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

C. Differences between research groups in activity completion

In all pilots, the treatment group had higher completion rates for education and training activities than the control group (Exhibit VI.3; Appendix Table C4). The magnitude of the differences varied across pilots but was largest in Mississippi (ECCS; 26 percentage point difference; 47 versus 21 percent) and smallest in California (ES) and Georgia (7 percentage point differences; 43 versus 36 percent for California [ES] and 27 versus 20 percent for Georgia).

Across pilots, the treatment group was more likely than the control group to complete an activity, but the magnitude of the differences varied.

Exhibit VI.3. Percentage of treatment and control group members who completed education and training activities



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

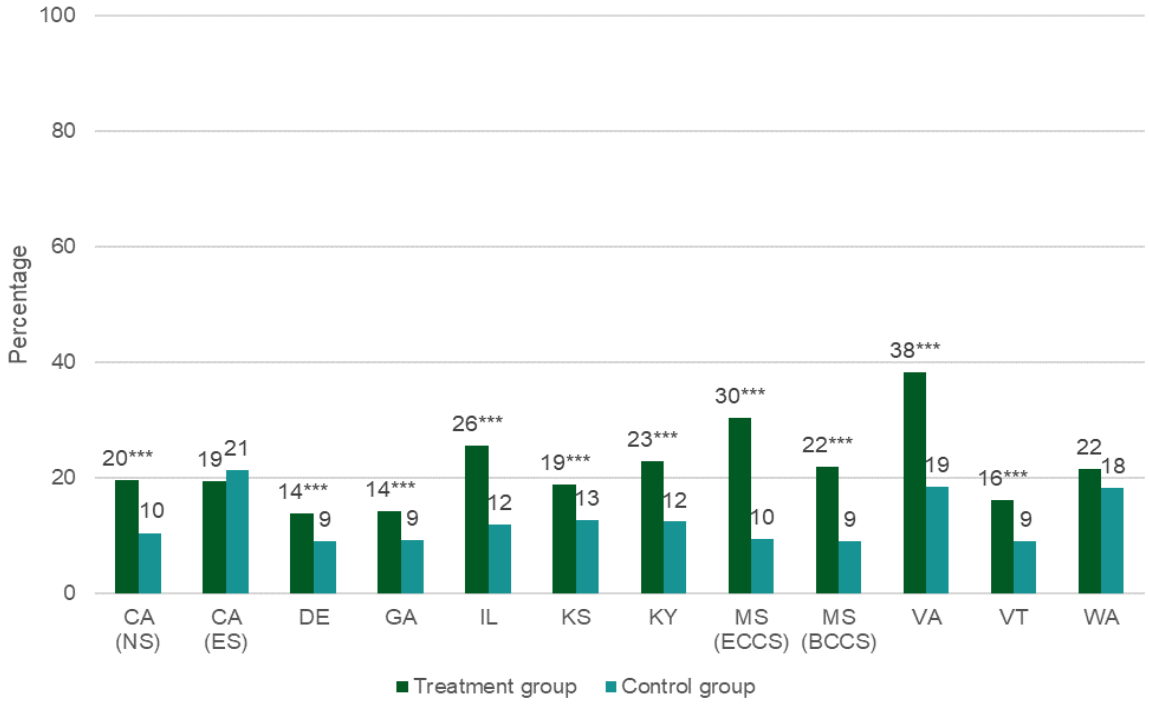
(CA (NS) $p < 0.001$, CA (ES) $p = 0.094$, DE $p = 0.002$, GA $p = 0.003$, IL $p < 0.001$, KS $p = 0.001$, KY $p < 0.001$, MS (ECCS) $p < 0.001$, MS (BCCS) $p = 0.003$, VA $p < 0.001$, VT $p < 0.001$, WA $p < 0.001$)

For most pilots, differences in completion rates between the treatment and control groups were largest in the first year after random assignment and decreased in Years 2 and 3 (Appendix Table C.5). For example, in Vermont, there was an 8 percentage point difference between completion rates of the

treatment and control groups in Year 1 (17 versus 10 percent with rounding), but the difference decreased to 6 percentage points in Year 2 (11 versus 5 percent) and 4 percentage points in Year 3 (10 versus 6 percent).

In nearly all pilots, the treatment group was more likely than the control group to receive an occupational certificate or license (Exhibit VI.4; Appendix Table C.4). The magnitude of the statistically significant differences varied across pilots but was largest in Mississippi (ECCS; 21 percentage point difference; 30 versus 10 percent with rounding) and Virginia (20 percentage point difference; 38 versus 19 percent with rounding) and smallest and not statistically significant in California (ES; -2 percentage point difference; 19 versus 21 percent) and Washington (3 percentage point difference; 22 versus 18 percent with rounding).

Exhibit VI.4. Percentage of treatment and control group members who received an occupational certificate or license



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community cllege services; ES = enhanced services; NS = no services

(CA (NS) $p < 0.001$, DE $p = 0.009$, GA $p = 0.005$, IL $p < 0.001$, KS $p = 0.007$, KY $p < 0.001$, MS (ECCS) $p < 0.001$, MS (BCCS) $p < 0.001$, VA $p < 0.001$, VT $p = 0.005$)

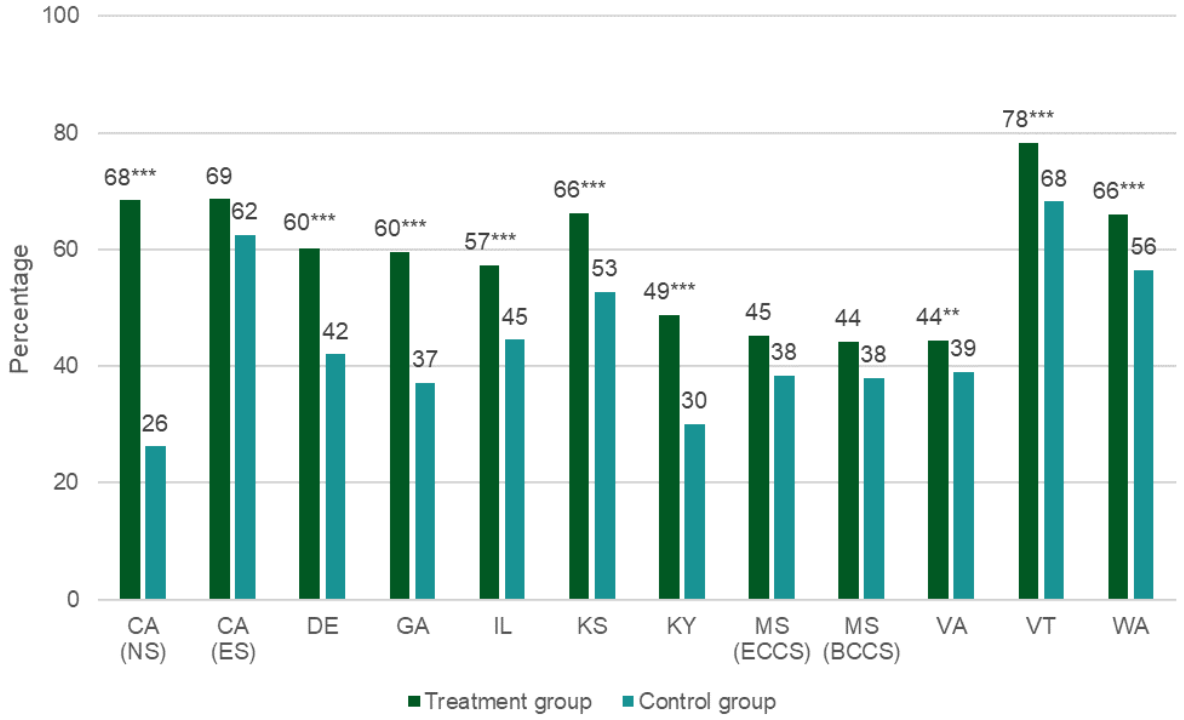
Similar to rates of completion, differences in receipt of an occupational certificate or license between the treatment and control groups were largest in the first year after random assignment and decreased in subsequent years (Appendix Table C.5). In each of the 10 pilots, the treatment group was more likely than the control group to receive an occupational certificate or license in Year 1 (although there was no difference between the California treatment group and the ES control group). Treatment-control

differences in receiving an occupational certification or license were significant in 6 pilots in Year 2 and 3 pilots in Year 3.

D. Differences between research groups in the receipt of case management and support services

In all pilots except Mississippi and California (ES), the treatment group was significantly more likely than the control group to receive case management services (Exhibit VI.5). Significant differences between research groups ranged from 6 percentage points (in Virginia; 44 versus 39 percent with rounding) to 42 percentage points (in California [NS]; 68 versus 26 percent). In all pilots, the treatment group also had more contacts with an employment professional or case manager relative to the control group (an average of two to eight more contacts per person over the three years following random assignment; not shown).

Exhibit VI.5. Percentage of treatment and control group members who received career counseling or one-on-one assistance from an employment professional or case manager



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

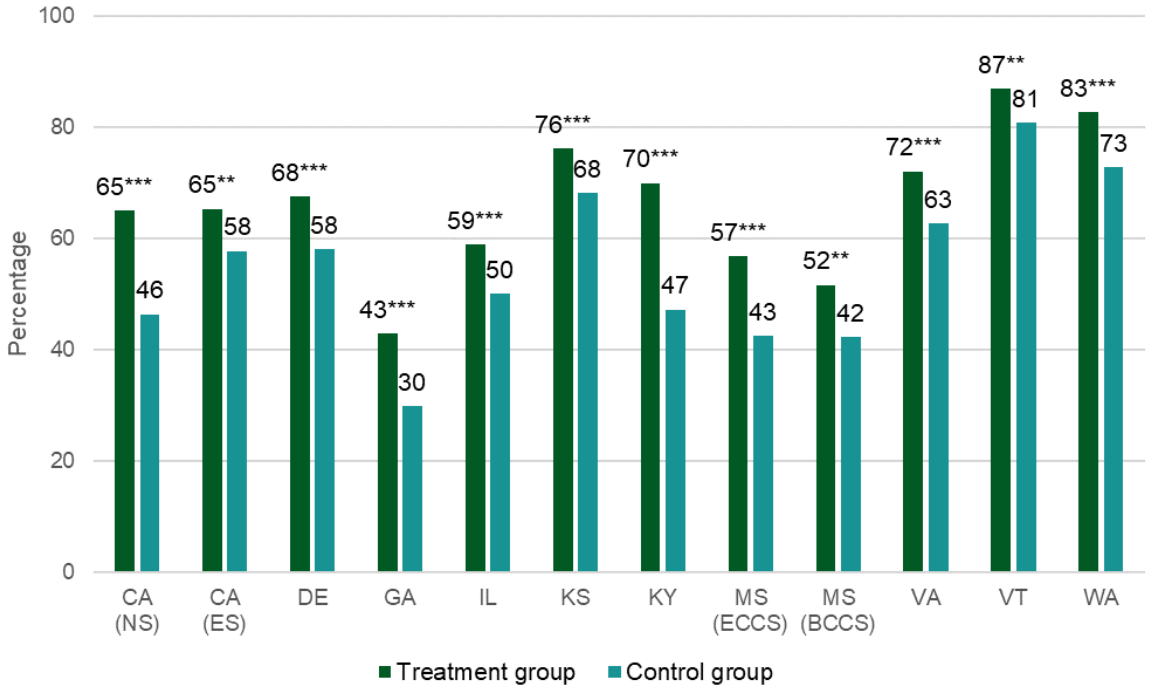
BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(CA (NS) $p < 0.001$, DE $p < 0.001$, GA $p < 0.001$, IL $p < 0.001$, KS $p < 0.001$, KY $p < 0.001$, VA $p = 0.041$, VT $p = 0.002$, WA $p = 0.005$)

In all pilots, the treatment group was more likely than the control group to receive support services (Exhibit VI.6). The difference ranged from 6 percentage points in Vermont (87 versus 81 percent) to 23 percentage points in Kentucky (70 versus 47 percent). The largest treatment-control group differences in

the receipt of support services—found in Kentucky, California (NS), Mississippi (ECCS), and Georgia—were generally due to low rates of support service receipt among control group members rather than especially high rates of support service receipt among treatment group members (Appendix Table C.6). Treatment group members were also more likely than control group members to receive supports in the form of transportation assistance, such as gas cards or bus passes; and clothes, uniforms, tools, or other supplies and equipment (not shown).

Exhibit VI.6. Percentage of treatment and control group members who received any support service



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(CA (NS) $p < 0.001$, CA (ES) $p = 0.045$, DE $p = 0.001$, GA $p < 0.001$, IL $p = 0.001$, KS $p = 0.005$, KY $p < 0.001$, MS (BCCS) $p = 0.003$, MS (ECCS) $p = 0.042$, VA $p < 0.001$, VT $p = 0.039$, WA $p = 0.001$)

VII. Impacts on earnings, SNAP participation, and other outcomes

In this chapter, we examine whether the enhanced services offered to individuals in the treatment group led to impacts on earnings, employment, receipt of public assistance, and food security. As described in Chapter II, while we examine impacts over the entire three-year period after random assignment, we focus on impacts in the two-year period consisting of Years 2 and 3. We aimed to measure outcomes as far after random assignment as possible to avoid measuring them when individuals were most likely to be receiving services and participating in activities (Year 1), and not measure them solely in Year 3, when the COVID-19 pandemic could have affected outcomes.

We begin by presenting findings from the two primary (confirmatory) outcomes: earnings (based on both UI and survey data)[23] and SNAP participation (based on administrative records). Next, we discuss impacts on employment and food insecurity. With the exception of food insecurity, each section presents the impact in Years 2 and 3, followed by a description of the patterns of impacts on earnings, SNAP participation, and employment throughout the follow-up period. These findings support those for the primary outcomes by examining whether they fit within a pattern of similar impacts.

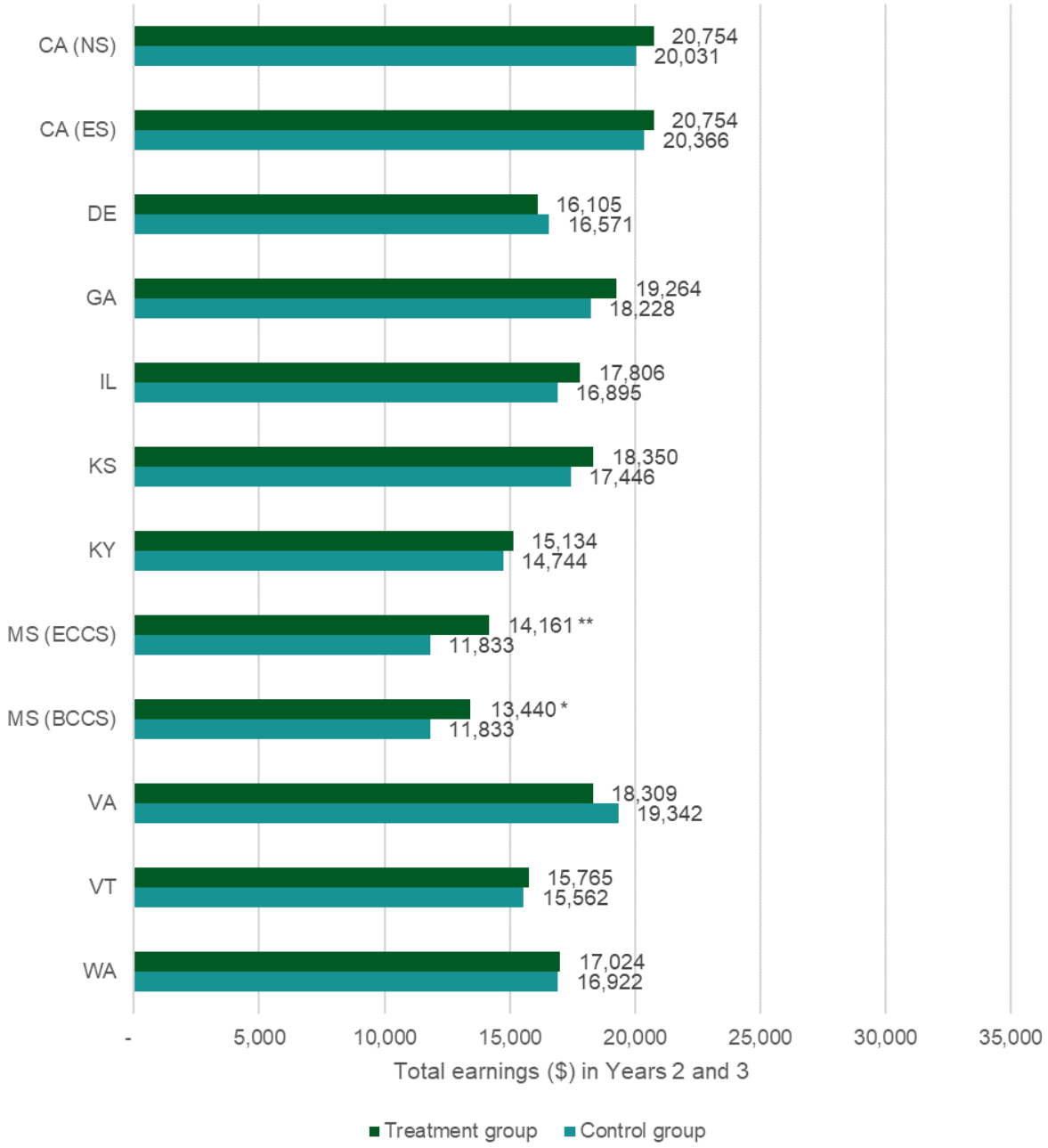
A. Impacts on earnings

In California, Mississippi, and Virginia, the enhanced services offered to the treatment group led to an increase in average earnings in the two-year period following random assignment (Years 2 and 3) based on UI wage records or survey data (Exhibits VII.1 and VII.2, respectively). Relative to the respective control groups in each pilot, average earnings were $2,328 (ECCS) and $1,608 (BCCS) higher (with rounding) for Mississippi's treatment groups, $3,938 higher for the treatment group in California (relative to the NS control group), and $2,761 higher for the treatment group in Virginia (with rounding) (Appendix Table D.1). There were no impacts on earnings in the other seven pilots.

In the two-year period, enhanced services and activities led to an increase in earnings in three pilots (California, Mississippi, and Virginia) but had no effect in the seven other pilots.

[23] Each data source has advantages and disadvantages in data coverage and accuracy. They are described in the 10 pilot-specific final evaluation reports and the technical supplement.

Exhibit VII.1. Total earnings, based on UI wage records in Years 2 and 3



Source: SNAP employment and training evaluation UI wage records, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

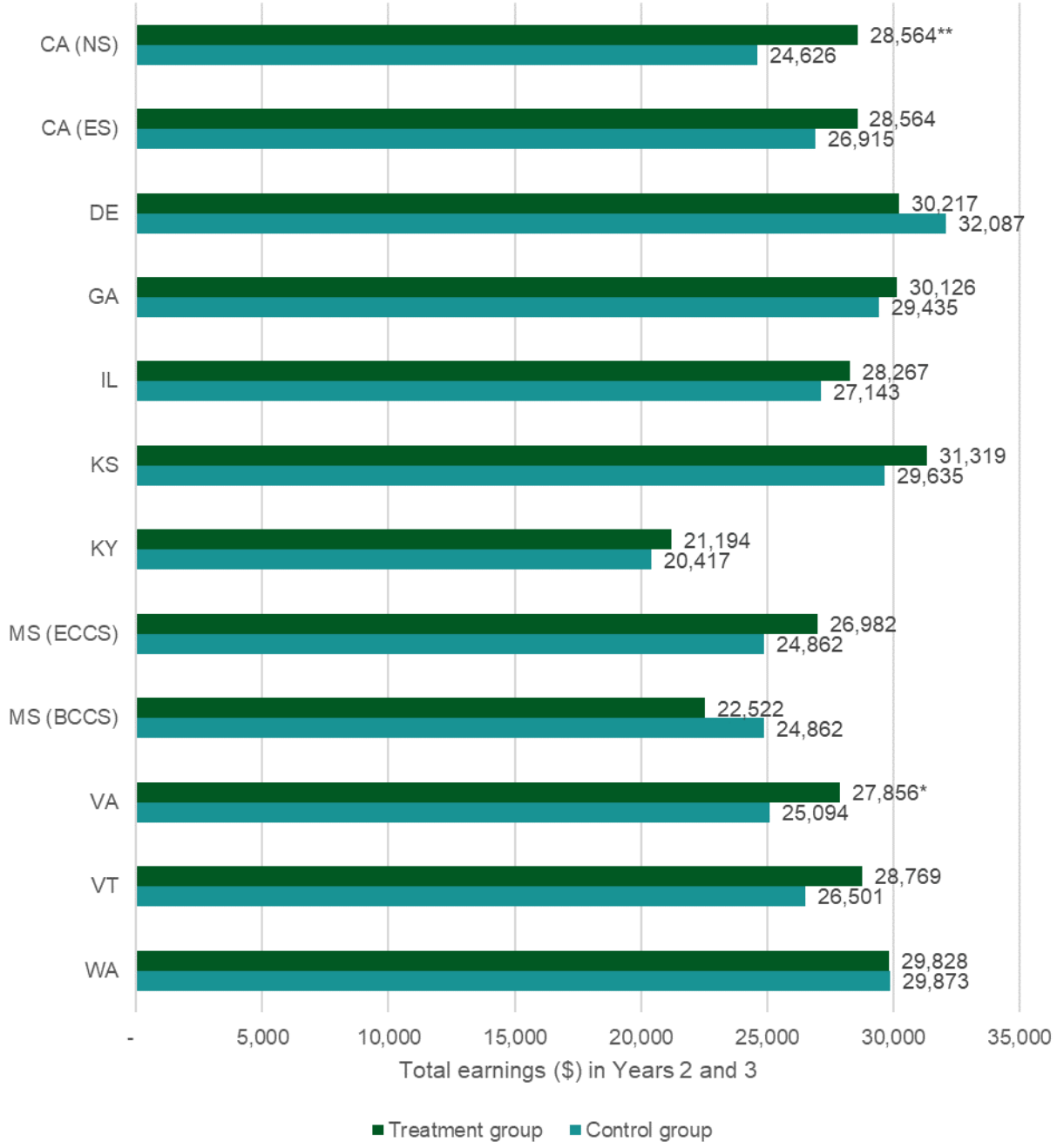
**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(MS (ECCS) p = 0.012, MS (BCCS) p = 0.072)

Exhibit VII.2. Total earnings, based on survey data in Years 2 and 3



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(CA (ES) p = 0.012, VA p = 0.041)

Analyses of earnings throughout the three years following random assignment provide useful information about patterns of impacts over time. As mentioned above, pilot services offered to the treatment group led to impacts on earnings in the two-year period (Years 2 and 3) in California, Mississippi, and Virginia. However, there were several patterns of effects on earnings in these and other pilots across each of the three years following random assignment (Appendix Table D.3):

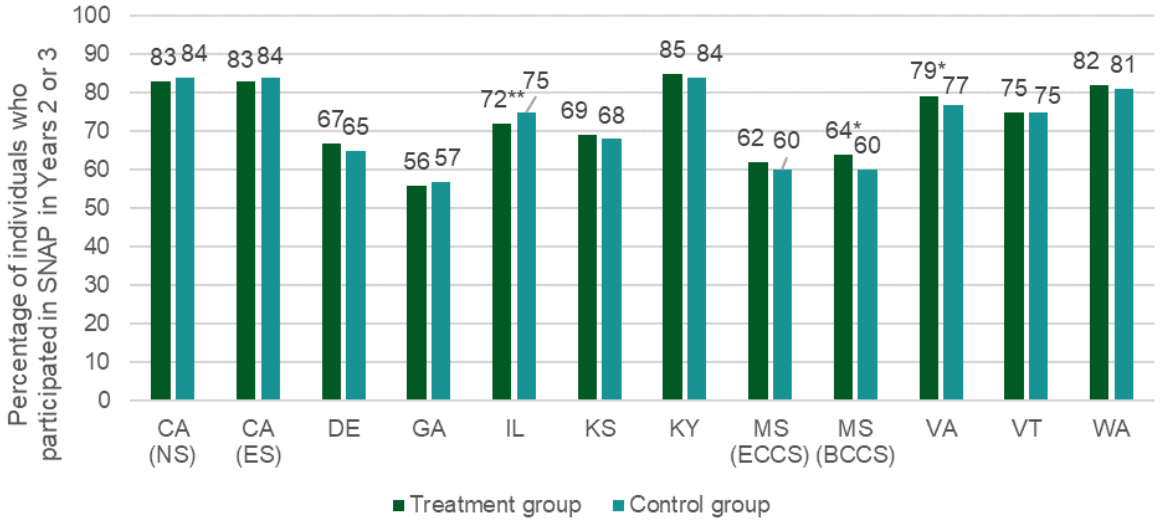
- **Some pilots had impacts only toward the end of the three-year period.** The three pilots (California [NS], Mississippi, and Virginia) that had impacts on earnings in the two-year period (Years 2 and 3) had different patterns of findings across the three years. California (NS) had impacts in each of the three years, Mississippi (BCCS) had impacts only in Year 2, Mississippi (ECCS) had impacts in Years 2 and 3, and Virginia had an impact only in Year 3. Although there was no impact in Illinois in the two-year period (Years 2 and 3), there was an impact in Year 3.
- **Some pilots had impacts on earnings early in the follow-up period, but they were not sustained.** There were no impacts on earnings over the two-year period in Kansas and Delaware. In Kansas, however, there was an increase in earnings in Year 2 based on UI data and a similar pattern, though statistically insignificant, based on survey data. In Delaware, average earnings were lower in the treatment group than the control group in Year 1 based on UI data and in Year 1 and Year 2 based on survey data; however, there were no statistically significant differences between research groups in other years.
- **Some pilots had no impacts on earnings in any year.** This finding was true for California [ES], Georgia, Kentucky, Vermont, and Washington.

B. Impacts on SNAP participation

In Illinois, Mississippi, and Virginia, the enhanced services offered to the treatment group affected the rate of SNAP participation over the two-year period (Years 2 and 3; Exhibit VII.3). In Illinois, the pilot services led to a statistically significant reduction in the likelihood of participating in SNAP (72 percent of the treatment group versus 75 percent of the control group). In two other pilots (Mississippi [BCCS] and Virginia), enhanced services led to a statistically greater likelihood of participating in SNAP in this period compared with the control group. SNAP participation rates for the treatment group, relative to the control group, were 4 percentage points higher in Mississippi (BCCS) and 2 percentage points higher in Virginia. In these pilots, the decrease over time in SNAP participation was smaller for the treatment group than the control group, resulting in the treatment group being more likely than the control group to participate in SNAP in the two-year period. In the remaining pilots, the enhanced services had no effect on rates of SNAP participation in the two-year period.

With the exception of one pilot (Illinois), the availability of treatment group services did not decrease the likelihood of participation in SNAP. The pilot services offered increased the likelihood of SNAP participation in two pilots (Mississippi and Virginia) and did not affect it in the others.

Exhibit VII.3. SNAP participation rates in Years 2 and 3



Source: SNAP employment and training evaluation SNAP administrative data, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(IL p = 0.050, MS (BCCS) p = 0.097, VA p = 0.061)

Services offered to the treatment group led to a decrease in SNAP participation among treatment group members in Illinois and an increase among those in Mississippi and Virginia relative to the control groups in the two-year period (Years 2 and 3). However, there were several patterns of effects on SNAP participation in these and other pilots across each of the three years following random assignment (Appendix Table D.4):

- **In some pilots, the treatment group had higher rates of SNAP participation than the control group early in the follow-up period, but these differences were not sustained in later years.** This pattern was true for Delaware (Years 1 and 2), Georgia (Year 1), Kansas (Year 1), Mississippi (BCCS; Years 1 and 2), and Virginia (Year 2).
- **In some pilots, there were no impacts or consistent pattern of impacts on SNAP participation in any year.** There were no impacts in California (ES), Vermont, and Washington in any year. In addition, in Mississippi (ECCS), the SNAP participation rate for the treatment group was greater in Year 2 and lower in Year 3 relative to the control group.
- **In some pilots, the treatment group had lower rates of SNAP participation than the control group in one or more years.** This pattern was true for California (NS) in Year 3 and Illinois in Years 2 and 3.

C. Impacts on employment

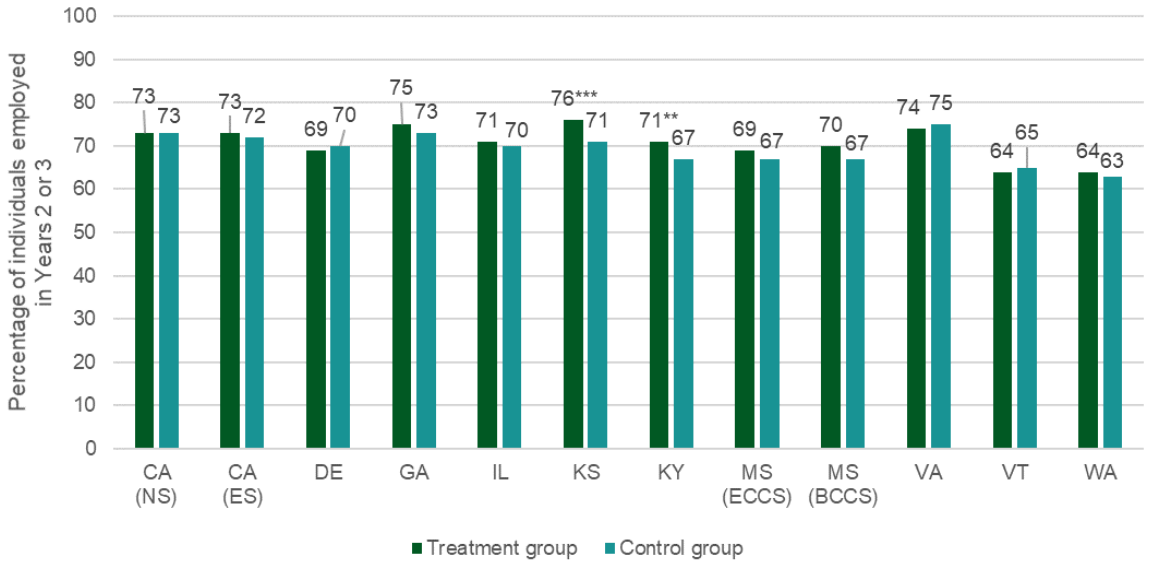
In 5 of the 10 pilots, the pilot services offered to the treatment group increased employment over the two-year period based on UI wage records or survey data. Based on UI wage records (Exhibit VII.4), the pilot

services offered to the treatment group led to a 5 percentage point increase in employment in Kansas and a 4 percentage point increase in Kentucky. Based on survey data (Exhibit VII.5), the enhanced services led to a 4 percentage point increase in employment in Kansas and 6 percentage point increases in California (NS), Illinois, and Vermont (with rounding).

The enhanced services led to an increase in employment in five pilots (California [NS], Illinois, Kansas, Kentucky, and Vermont).

Out of these 5 pilots with impacts on employment, 4 did not have a corresponding impact on earnings. Thus, California (NS) was the only pilot to have an increase in both earnings and employment.

Exhibit VII.4. Employment rate, based on UI wage records in Years 2 and 3



Source: SNAP employment and training evaluation UI wage records, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

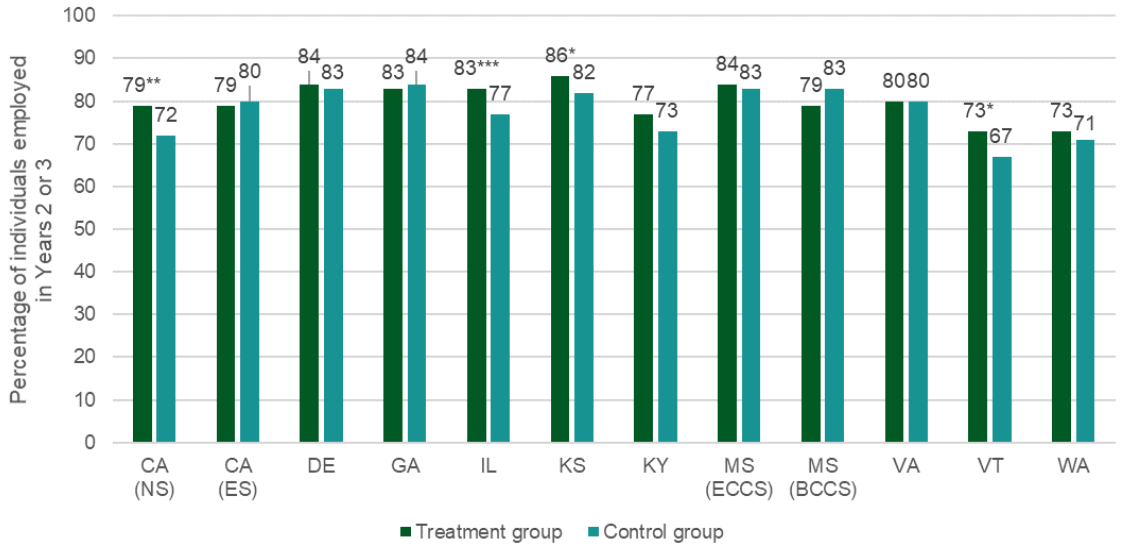
**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(KS p = 0.002, KY p = 0.016)

Exhibit VII.5. Employment rate, based on survey data in Years 2 and 3



Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data

***Difference between research groups is significantly different from zero at the 0.01 level, two-tailed test.

**Difference between research groups is significantly different from zero at the 0.05 level, two-tailed test.

*Difference between research groups is significantly different from zero at the 0.10 level, two-tailed test.

BCCS = basic community college services; ECCS = enhanced community college services; ES = enhanced services; NS = no services

(CA (NS) p = 0.012, IL p = 0.006, KS p = 0.078, VT p = 0.071)

Looking across the full three-year follow-up period, in some pilots, there were no impacts on employment in any year (California [ES], Delaware, Georgia, Mississippi [ECCS], and Washington) or inconsistent patterns of findings (Mississippi [BCCS] had an increase in employment in Year 2 based on UI data and a decrease in Year 3 based on survey data; Appendix Table D.5).

D. Impacts on food insecurity

The enhanced services reduced food insecurity in one pilot (California) and very low food security in two pilots (California and Mississippi). There was no effect on food insecurity in the other pilots.

In 9 of the 10 pilots, the pilot services offered to the treatment group did not lead to a reduction in the percentage of individuals living in households that were food insecure three years after random assignment as assessed at the time of the 36-month survey (Appendix Table D.6). This finding is not surprising, given that such reductions would be expected to result from increases in earnings, which were observed in only three pilots. The rate of food insecurity was lower for the treatment group than the control group in California (NS; 7 percentage point difference). Similarly, in 8 pilots, the pilot services offered to the treatment group did not lead to a reduction in the percentage of individuals living in households that experienced very low food security (a severe form of food insecurity) 36 months after random assignment. The rate of very low food security was lower for the treatment group than the control group in Mississippi (BCCS; 10 percentage point difference) and California (NS; 8 percentage point difference). This likely reflects that they were two of the three pilots that experienced increases in earnings among the treatment group relative to the control group.

VIII. Analysis of the costs and benefits of treatment and control group services

In this chapter, we build on the findings from the impact analysis by comparing the benefits that individuals received in dollar terms through changes in earnings and public assistance with the costs of the services provided. This cost-benefit analysis describes the extent to which the benefits exceeded the costs of providing services to the treatment groups when compared with the benefits and costs of providing services to the control groups (called the *net benefit*). The net benefit provides context for how well treatment group outcomes (benefits) offset the costs of providing the services in which treatment group members participated. We calculate the net benefit from the perspective of the individuals enrolled in the treatment group as well as that of the government and taxpayers. The net benefit to society is the sum of the net benefits from these two perspectives.

We first describe the costs of the pilots, including those associated with planning and developing the pilots, recruiting treatment and control group members, and delivering pilot services.[24] Next, we present the estimated costs of all services in which treatment and control group members participated. For the treatment groups, these costs include those of services provided through the pilots, existing SNAP E&T programs, and the community. We consider costs associated with existing SNAP E&T and community-based services because any benefits individuals in the treatment groups experienced were influenced by all of the services they received —not just those offered through the pilots. Costs for the control groups reflect services available through existing SNAP E&T programs or the community. We then present findings from the cost-benefit analysis and estimate the net benefit of services provided to the treatment groups compared with those provided to the control groups. We also discuss the results of sensitivity analyses we conducted to test the robustness of our findings. We adjusted all costs and the dollar values of benefits to 2016 dollars—the year the pilots started providing services and individuals started accruing benefits.

A. Costs of developing and implementing the pilots

FNS awarded grants ranging from approximately $9,000,000 to $22,330,000 to cover costs, including those for planning and developing the pilots, recruiting treatment and control group members, and providing treatment group services through 2019, when the pilots ended. Total reported costs varied widely across the pilots, from $6,813,186 in Georgia to $23,362,819 in Washington (Exhibit VIII.1). These reported costs included $109,820 to $2,282,258 for planning, $103,687 to $4,154,067 for recruitment, and $5,037,510 to $16,926,494 for providing services. In all pilots, service costs accounted for more than 70 percent of total costs. In 7 of the 10 pilots, recruitment costs accounted for more than 10 percent of total costs, reflecting the significant efforts required to recruit and enroll treatment and control group members. Planning period costs generally were less than 10 percent of total costs across pilots. The FNS grant funded more than three-quarters of total costs in most pilots; remaining funds were leveraged from other sources.

Total costs were highest for Washington ($23,362,819)—about 6 percent more than its total grant funding of $22,000,000. Washington's costs were more than 3 times the costs of Georgia's pilot and almost 1.5

[24] The costs of services included costs of both ongoing administration and delivering direct services and activities. We hereafter refer to services and activities as "services."

times the cost of the Illinois pilot. This difference is due in part to Washington's large number of providers (36 over the course of the pilot), all of which hired pilot staff and incurred their own overhead costs. Total costs were lowest in Georgia ($6,813,186). Most pilots spent less than three quarters of the total grant funding they received (not shown). Lower than anticipated enrollment and participation in services likely contributed to these differences between the funding and expenditures.

Exhibit VIII.1. Total pilot costs across grantees

Pilots	Total grant funding	Total costs	Planning period costs	Recruitment costs	Treatment group service costs	Percentage of total costs funded by the grant[a]	Average costs of pilot services per treatment group member[b]
CA	$12,167,000	$9,194,027	$197,736	$1,784,252	$7,212,038	78.9	$5,682
DE	$18,765,000	$12,785,610	$1,028,609	$2,640,013	$9,116,988	85.9	$2,857
GA	$15,011,000	$6,813,186	$109,820	$1,665,856	$5,037,510	88.8	$2,029
IL	$21,858,000	$16,323,517	$279,680	$2,343,380	$13,700,457	74.0	$5,477
KS	$13,509,000	$10,631,954	$493,113	$987,891	$9,150,949	92.4	$4,452
KY	$19,987,000	$13,056,631	$610,971	$755,064	$11,690,595	97.7	$7,382
MS	$22,246,000	$11,361,122	$1,089,769	$1,602,220	$8,669,133	77.6	$4,912[a]
VT	$8,959,000	$8,868,903	$197,050	$1,367,357	$7,304,496	77.0	$4,843
VA	$22,330,000	$14,800,044	$281,527	$103,687	$14,414,829	98.2	$5,741
WA	$22,000,000	$23,362,819	$2,282,258	$4,154,067	$16,926,494	72.6	$6,706

Sources: SNAP employment and training evaluation actual reported costs by grantee, partners, and providers, 2015–2019; and SNAP employment and training evaluation survey of direct service provider time use, 2016–2018

Notes: The planning period included the time period between grant award and when grantees started enrolling individuals (Spring 2015 to Spring 2016). Grantees submitted quarterly workbooks to report costs incurred for the planning period, recruitment, and provision of treatment group services. We used data from a time use survey of direct service providers to estimate the breakdown of recruitment, direct services, and ongoing administration costs. We present all costs in 2016 dollars.

[a] The percentage of total costs funded by the grant is the percentage of the costs from the workbooks that pilots reported spending from grant funding. The remaining costs were funded by other sources, even if the pilot reported spending less than the total grant funding.

[b] The table includes the average cost of pilot services per individual for the ECCS group. The value for the BCCS group was $3,909 per individual.

The average costs of pilot services per treatment group member ranged from $2,029 in Georgia to $7,382 in Kentucky. These costs were divided between those for operating treatment group services and the resources provided directly to treatment group members, such as subsidized earnings and support services (not shown). Across the pilots, the costs of operating treatment group services accounted for 39 to 99 percent of total costs per individual. Subsidized earnings and support services accounted for 0 to 32 percent or 1 to 28 percent of costs per individual, respectively.

Pilot services cost an average of $2,029 to $7,382 per individual.

We estimated the costs of specific types of services, such as assessment, case management, and occupational skills training. In some pilots, a single type of service accounted for a large share of costs, such as Kansas, which incurred more than half of service costs for education (32 percent) and support

services (23 percent), and Vermont, which incurred almost two-thirds of these costs for case management (30 percent) and support services (31percent; Exhibit VIII.2). Other pilots' costs were distributed more evenly across types of services; in general, no specific service represented more than 20 percent of service costs.

Exhibit VIII.2. Percentage of service costs, by type of service

Pilots	Assessment	Case management	Support services	Job readiness or life skills workshops	Education[a]	Occupational skills training	Work-based learning	Other[b]
CA	6.0	23.6	6.4	20.4	2.5	19.4	21.7	0.0
DE	16.6	43.0	12.9	14.0	0.9	9.7	0.2	2.8
GA	29.6	23.7	2.8	9.6	0.0	33.6	0.7	0.0
IL	11.4	15.5	8.0	15.8	2.0	25.3	16.3	5.8
KS	6.3	23.6	22.6	11.7	32.4	2.4	0.0	1.0
KY	1.1	12.5	32.8	0.6	9.9	5.6	37.2	0.3
MS	8.6	23.1	17.0	12.1	0.5	10.7	27.9	0.0
VT	6.7	30.2	31.2	10.3	0.4	1.4	19.8	0.0
VA	0.8	10.9	4.2	68.8	4.4	10.1	0.0	0.7
WA	8.5	43.8	23.4	13.4	2.2	0.9	7.8	0.0

Sources: SNAP employment and training evaluation actual reported costs by grantee, partners, and providers, 2015–2019; and SNAP employment and training evaluation survey of direct service provider time use, 2016–2018

Notes: Service costs included the costs of direct services and ongoing administration. Administration costs were allocated proportionally across direct service costs. In practice administration efforts for a given direct service type may not have been proportionate to the direct service cost. We present all costs in 2016 dollars.

[a] Education included activities related to adult basic education, GED, or postsecondary education (referred to as basic education and post-secondary education in Chapter III).

[b] Other direct services included contracts for treatment group services which did not fall into one of the other service categories, such as a contract to support collection of case management and participation data.

B. Costs of services in which treatment and control group members participated

In this section, we describe the costs associated with the services in which treatment and control group members participated. For the treatment groups, costs included those of services provided through the pilots and those provided through existing SNAP E&T programs and the community. For the control groups, costs reflect services provided through existing SNAP E&T programs and the community.[25]

In the cost-benefit analysis, we used the difference in the average costs of all services treatment and control group members received (per individual) and compared them to benefits. The cost-benefit analysis assessed whether the enhanced services that the pilots offered were effective enough to offset the difference in costs for the services the treatment and control groups received. The services the control group received are indicative of the services that treatment group members would have received if the

[25] Most grantees were unable to report detailed information on costs for the services received by control group members. As a result, we estimated the costs of all services control group members received using recently published data on the costs of similar services offered through the WIOA Adult and Dislocated Worker programs. We used cost data from the WIA (Workforce Investment Act) Gold Standard Evaluation and FNS-583 data on support services to estimate the costs of control group services. We provide more detail on this methodology in the technical appendix.

pilots had not been in place. We used these differences in costs because impacts of the pilots on individuals' outcomes, such as earnings, were influenced by all services all sample members received during the 36-month follow-up period, not just those that the treatment group received through the pilots.

The difference between total service costs for the treatment and control groups could reflect multiple factors, including how many services individuals received, how long the average individual spent in a given type of service or in services overall, or how much staff time or other resources those services required. Exhibit VIII.3 presents estimated costs overall and per individual of services treatment group members received through the pilots and of all services treatment and control group members received. The costs of pilot services that treatment group members received ranged from $5,037,510 to $16,926,494. Based on data from the 12- and 36-month follow-up survey, the estimated costs of all treatment group services ranged from $5,238,423 in Georgia to $27,545,011 in Washington. On average, these estimates are about 10 percent higher than the cost of pilot services alone, suggesting that treatment group members might have received some services from the existing SNAP E&T program or community-offered sources.[26] For example, the costs of all services treatment group members received in Kansas were about 12 percent higher than the costs of pilot services alone ($10,261,586 versus $9,150,949, respectively).

All treatment group services cost an average of $1,750 to $8,672 per individual. All control group services cost an average of $1,069 to $3,174 per individual.

The control group had access only to services available through the existing SNAP E&T program or within the community. The estimated cost of all control group services received ranged from $1,981,125 in California's NS group to $7,232,984 in Washington, including costs for direct services and ongoing administration. In most pilots, this cost was less than a third of the cost of all treatment group services.

Treatment and control group members each received different combinations of services, and the costs of serving each individual varied based on the number and types of services in which they participated. In addition to providing context for the costs required to provide these types of services to individuals, the per-individual costs of all treatment and control group services were the basis for the cost differentials used in the cost-benefit analysis. The per-individual costs for all services that treatment group members received averaged between $1,750 and $8,672 across pilots. The largest component of these costs generally was operating costs, which accounted for more than 75 percent of costs per individual in 8 of 10 pilots. The costs of subsidized earnings and support services accounted for a smaller share of the overall cost—costs of subsidized earnings ranged from 0 to 20 percent of costs per treatment group member, and support services generally accounted for less than 5 percent of costs per treatment group member.

The costs of all services that control group members received averaged between $1,069 and $3,174. Similar to treatment group costs, the largest component generally was operating costs, which accounted for 70 to 80 percent of costs in most pilots. The costs of subsidized earnings and support services

[26] The difference between the costs of the pilot services in Section A and the costs presented for treatment group members in this section could reflect services that treatment group members received outside of the pilots, but also the difference between administrative records of service use and each individual's recollection of services they received during the follow-up period. We examined the sensitivity of our findings to the use of these different data sources and found variation in reported participation in services by type, but the overall costs of services for the treatment group generally were similar and did not change the results of the cost-benefit analysis.

accounted for a smaller share of the overall cost—costs for subsidized earnings ranged from 14 to 29 percent of costs per control group member, whereas costs for support services accounted for less than 6 percent per control group member in all pilots. The cost of all services per control group member generally was less than half of the cost of all services per treatment group member, on average.

Exhibit VIII.3. Total costs of treatment and control group services across grantees

	Pilot services treatment group members received		All services treatment group members received[a]		All services control group members received	
Pilots	Service costs	Average costs per individual	Service costs	Average costs per individual	Service costs	Average costs per individual
CA (ES)	$7,212,038	$5,682	$8,619,943	$6,320	$2,021,686	$1,380
CA (NS)	--	--	--	--	$1,981,125	$3,174
DE	$9,116,988	$2,857	$8,309,641	$1,750	$5,240,165	$1,392
GA[b]	$5,037,510	$2,029	$5,238,423	$2,389	$2,799,942	$1,069
IL[b]	$13,700,457	$5,477	$13,026,587	$4,869	$4,671,604	$1,795
KS	$9,150,949	$4,452	$10,261,586	$6,074	$4,750,408	$2,206
KY[b]	$11,690,595	$7,382	$13,545,461	$8,672	$3,928,256	$2,434
MS (ECCS)	$8,669,133	$4,912	$7,173,518	$4,565	$2,007,671	$1,909
MS (BCCS)	--	$3,909	$6,829,419	$3,673	--	--
VT	$7,304,496	$4,843	$9,549,204	$7,113	$3,717,716	$2,229
VA	$14,414,829	$5,741	$13,766,053	$5,046	$4,794,514	$1,822
WA	$16,926,494	$6,706	$27,545,011	$7,884	$7,232,984	$2,566

Sources: SNAP employment and training evaluation actual reported costs by grantee, partners, and providers, 2015–2019; and SNAP employment and training evaluation survey of direct service provider time use, 2016–2018; WIA Gold Standard Evaluation cost estimates, 2012; FNS-583 data 2018; SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Notes: A double dash indicates that the estimate is included in the estimate for the other research group within the pilot; we report the ES and NS control groups together for California and ECCS and BCCS groups together for Mississippi. We calculated estimates of the cost of all services treatment and control group members received as the product of the costs per treatment group member for each type of direct service and the number of treatment group members who received each type of direct service as reported in the SNAP employment and training evaluation 12- and 36- month survey data. We calculated control group cost estimates as the product of the WIA costs per individual for each type of direct service and the number of control group members who received each type of direct service as reported in the SNAP employment and training evaluation 12- and 36- month survey data. Average costs represent those for services received during the pilot service period, which generally was from early 2016 through early 2019 across pilots. We present all costs in 2016 dollars.

[a] The costs of all services treatment group members received were similar to or less than the costs of pilot services alone that treatment group members received in several pilots (Delaware, Georgia, Illinois, Mississippi, and Virginia). We calculated the costs of all services treatment group members received using 36-month follow-up survey data reflecting individuals' recall of services they received during the pilot service period. The costs of pilot services alone are based on pilot-reported cost and participation data. Differences between these estimates could suggest that, on average, individuals did not receive many services outside of the pilot through the existing SNAP E&T program or community.

[b] In all or part of this State, the control group only had access to services available within the community because the State did not offer a SNAP E&T program at the time of the evaluation.

C. Cost-benefit analysis of treatment group services

The purpose of the cost-benefit analysis was to estimate the benefits in dollar terms relative to the dollar costs of providing services. We present the findings of the cost-benefit analysis in this section using the two sources of data on benefits used in the impact analysis: (1) UI wage records and (2) 36-month survey data.[27] The cost-benefit analysis used a framework to present a comprehensive listing of treatment group benefits and costs relative to the control group from multiple perspectives, including those of (1) treatment group members enrolled in pilot services; (2) government and taxpayers; and (3) society as a whole, the last of which represents the sum of the other two perspectives. The primary cost-benefit finding from each perspective was the net benefit (the difference between total benefits and total costs). A positive net benefit means the benefits outweighed the costs, whereas a negative net benefit means the costs outweighed the benefits. In addition, we estimated the ratio of benefits to costs, which describes the return to society on each dollar invested. The benefit-cost ratio is the quotient of the total benefit and the absolute value of the total costs. We also describe how our results differed according to changes in these assumptions for each of the cost-benefit accounting frameworks presented below.

1. Costs and benefits of all services for treatment group members, based on UI wage records

The net benefits of services for the treatment group compared to the control group were generally negative for society during the 36-month follow-up period (Exhibit VIII.4). Although net benefits generally were positive for treatment group members because of earnings and support service payments they received in services, these benefits typically did not offset the costs of the services to government and taxpayers. For example, treatment group services in Kentucky cost society $4,438 more per individual than control group services. Treatment group members benefitted by $1,916 compared with the control group, resulting from higher cumulative earnings, fringe benefits, and support services. However, the costs of the program to government and taxpayers were not offset by benefits realized through tax payments or other reductions in public benefits, resulting in a cost of $6,354 per treatment group member.

*According to UI wage records, the net benefits of all services treatment group members received were **negative** for society during the 36-month follow-up period, compared to the control group. Net benefits generally were positive for treatment group members, but the costs to government and taxpayers exceeded those benefits.*

According to UI wage records, all treatment group services cost society between $409 and $4,894 per individual, on average. Only Mississippi had a net benefit to society, by $274 per ECCS group member and $300 per BCCS group member. Generally, the differential costs of treatment group services were not offset by the benefits accrued through earnings and fringe benefits during the 36-month follow-up period. The benefit-cost ratio, or return on investment to society, was close to zero in most pilots, meaning the costs of most pilots exceeded their benefits. Mississippi had a positive benefit-cost ratio for both the ECCS and BCCS groups, at $1.11 and $1.18, respectively, meaning that, from a societal perspective, Mississippi made between 11 and 18 cents on each dollar invested.

[27] We included impacts on cumulative earnings and SNAP and TANF benefit receipt in the cost-benefit analysis even if they were not statistically significant. These estimates are the best information we have on the qualitative differences in outcomes between the two groups. We noted any statistically significant impacts in the exhibits.

In most pilots, treatment group members benefitted from services on average, ranging from $73 to $3,858 per individual. Generally, receipt of support services accounted for most of the benefits to treatment group members. These support services were funded by government and taxpayers, meaning there was no benefit to society overall. In 9 of the 10 pilots, support services provided to treatment group members were more than $100 greater than those provided to control group members—a difference ranging from $108 to $1,781 (not shown). In Delaware and Virginia, there was a negative net benefit to treatment group members compared to the control group, (by $550 and $785, respectively), driven primarily by lower cumulative earnings.

Providing treatment group services cost government and taxpayers between $813 and $6,354 more per individual compared with control group services. This difference was due mostly to the cost of providing services (including those provided by the pilots, existing SNAP E&T programs, and the community), which averaged more than double the cost of providing control group services. In some pilots, treatment group members also received higher amounts of SNAP and TANF benefits relative to control group members, which was a cost to government and taxpayers in benefit allotments and administration costs. Few pilots had positive impacts on cumulative earnings, which would have benefitted government and taxpayers through higher taxes; generally, those benefits did not offset the higher costs of treatment group services.

Exhibit VIII.4. Benefits and costs associated with pilot, existing SNAP E&T, or community-offered services for the treatment group compared to the control group, UI wage records

	Net benefit by perspective ($)			Benefit-cost ratio
Pilot	Treatment group members	Government and taxpayers	Society	Return on each dollar invested
CA (ES)	845	-4,343	-3,499	0.28
CA (NS)	73	-2,620	-2,547	0.18
DE	-550	-813	-1,363	-3.57
GA	746	-1,155	-409	0.69
IL	553	-2,781	-2,228	0.25
KS	1,415	-3,663	-2,248	0.38
KY	1,916	-6,354	-4,438	0
MS (ECCS)	3,858	-3,584	274	1.11
MS (BCCS)	3,126	-2,826	300	1.18
VT	716	-4,812	-4,096	-0.05
VA	-785	-4,109	-4,894	-0.63
WA	485	-5,152	-4,667	0.01

Source: SNAP employment and training evaluation UI wage records, weighted data; SNAP administrative data; SNAP employment and training evaluation actual reported costs by grantee, partners, and providers, 2015–2019; SNAP employment and training evaluation administrative service use data; WIA Gold Standard Evaluation cost estimates, 2012; and SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Notes: Earnings, SNAP benefits, and TANF benefits are the impact estimates presented in Chapter VII. The net benefit is the difference between total benefits and total costs. A negative net benefit is a net cost. The benefit-cost ratio is the quotient of the total benefits and the absolute value of the total costs. A benefit-cost ratio greater than one represents greater benefits than costs; a number less than one suggests fewer benefits than costs. We present all costs in 2016 dollars.

Difference in cumulative 36-month earnings between the treatment group and control group significantly different from zero, two-tailed test: Mississippi (ECCS) 0.05 level; Mississippi (BCCS) 0.1 level; Virginia 0.05.

2. Costs and benefits of all services for treatment group members, based on 36-month survey data

The findings based on 36-month follow-up survey data were similar to those based on UI wage records. The net benefits of all treatment group services generally were positive for treatment group members but negative for government and taxpayers, and thus for society, during the follow-up period (Exhibit VIII.5).

*According to survey data, the net benefits of all services treatment group members received were more **positive** for treatment group members compared with UI wage records. In most pilots, however, net benefits were **negative** for government and taxpayers, and thus for society, during the 36-month follow-up period compared to control group members.*

According to survey data, all treatment group services cost society between $617 and $5,804 per individual, on average. In 7 of the 10 pilots, the negative net benefit to society was smaller according to survey data compared with UI wage records. In most pilots, this difference is accounted for by the difference in reported earnings for treatment group members according to survey data. There was a net benefit to society in California for the treatment group compared to the NS control group, by $991 per treatment group member, and in Georgia, by $112 per treatment group member. In most pilots, however, the differential costs of treatment group services were not offset by the benefits accrued through earnings and fringe benefits during the 36-month follow-up period. The benefit-cost ratio was closer to one in 4 of 10 pilots, meaning that pilots came closer to breaking even on each dollar invested. California (for the treatment group compared to the NS control group) and Georgia had positive benefit-cost ratios, at $1.21 and $1.08, respectively, meaning that, from a societal perspective, those pilots made between 23 and 8 cents on each dollar invested.

In some pilots, the increases in cumulative earnings for the treatment group relative to the control group were slightly higher according to survey data. Treatment group members experienced a net benefit of $752 to $4,587. However, even when accounting for these larger impacts on earnings, the benefits of treatment group services did not offset their costs during the follow-up period, on average. Other benefits and costs to individuals were the same as those in the findings based on UI wage records, with support services generally accounting for some of the benefits to treatment group members. In Delaware, Mississippi's BCCS group, and Washington, treatment group members received fewer net benefits compared to the control group (by $2,651, $1,810, and $457, respectively), driven by lower cumulative earnings and higher service costs.

Similar to findings based on UI wage records, providing treatment group services cost government and taxpayers between $1,041 and $6,182 more per individual compared with control group services, driven by the higher costs of treatment group services compared to control group services. These costs were not offset by benefits to government and taxpayers through taxes and reductions in public assistance costs during the 36-month follow-up period.

Exhibit VIII.5. Benefits and costs associated with pilot, existing SNAP E&T, or community-offered services for the treatment group compared to the control group, 36-month survey data

	Net benefit by perspective ($)			Benefit-cost ratio
	Treatment group members	Government and taxpayers	Society	Return on each dollar invested
CA (NS)	4,587	-3,596	991	1.21
CA (ES)	1,651	-2,332	-681	0.78
DE	-2,651	-1,421	-4,073	-12.64
GA	1,152	-1,041	112	1.08
IL	752	-2,719	-1,968	0.34
KS	2,391	-3,355	-964	0.730
KY	2,533	-6,182	-3,649	0.18
MS (ECCS)	1,941	-2,564	-624	0.75
MS (BCCS)	-1,810	-2,664	-4,474	-1.74
VT	2,473	-4,373	-1,900	0.51
VA	1,389	-2,006	-617	0.79
WA	-457	-5,347	-5,804	-0.23

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data; SNAP administrative data; SNAP employment and training evaluation actual reported costs by grantee, partners, and providers, 2015–2019; SNAP employment and training evaluation administrative service use data; and WIA Gold Standard Evaluation cost estimates, 2012.

Notes: Earnings, SNAP benefits, and TANF benefits are the impact estimates presented in Chapter VII. The net benefit is the difference between total benefits and total costs. A negative net benefit is a net cost. The benefit-cost ratio is the quotient of the total benefits and the absolute value of the total costs. A benefit-cost ratio greater than one represents greater benefits than costs; a number less than one suggests fewer benefits than costs. We present all costs in 2016 dollars.

Difference in earnings between the treatment group and control group significantly different from zero, two-tailed test: California (NS control group) 0.01 level.

3. Sensitivity analyses

We conducted a set of sensitivity analyses to assess whether the main conclusions were sensitive to the many assumptions inherent in any cost-benefit analysis. We checked the robustness of our estimates to a set of alternative assumptions, including (1) the values of benefits associated with increases in earnings, such as fringe benefits and taxes; (2) the values of costs and benefits when accounting for factors such as inflation and present value; (3) the assumption that subsidized earnings were reported to State UI agencies and reflected in earnings impacts; and (4) the services treatment group members received were primarily through the pilot and not from the existing SNAP E&T program or the community. The findings were robust to almost all changes in these assumptions for all pilots according to both UI wage records and survey data. Based on survey data, the net benefits to society in Kansas and Vermont were positive when restricting the costs of treatment group services to those received through the pilot, and negative according to the approach utilized for the results presented above, which used the costs of all services treatment group members received through the pilots, the existing SNAP E&T program, and the community.

IX. Conclusion

The goal of the 10 SNAP E&T pilots was to test innovative strategies to increase SNAP participants' employment and earnings, and reduce their need for public assistance benefits. Through its comprehensive data collection and rigorous experimental design, the evaluation assessed whether the enhanced pilot services each State designed and implemented were effective in achieving these goals.

We conducted several interrelated analyses that form the basis of this final report. Findings from the implementation analysis describe the planning and implementation of the pilots, their pilot services and operations, and lessons learned for sustaining or replicating the pilot services. Findings from the participation and impact analyses describe receipt of services, participation in activities, and impacts on individuals' outcomes for up to three years after enrollment. Finally, the cost-benefit analysis describes the costs of services and compares the benefits of receiving them to the costs of providing them. In this chapter, we summarize and discuss key findings from all of these analyses.

A. Summary of findings

The pilots offered new and innovative services that required careful coordination with other government agencies and providers in the community to create a network of pilot services for SNAP participants. Many pilots also targeted individuals who faced substantial barriers to participation in education or training-related activities or finding employment. Although some pilots experienced challenges, many were successful in recruiting and engaging individuals, and establishing and maintaining relationships with new partners and providers in the community.

In all of the pilots, treatment group members were more likely than control group members to start and complete an activity, and, in most pilots, receive support services. In some pilots, this increased engagement led to an increase in earnings over time. In most cases, however, the cost of implementing the pilot outweighed its benefits. We describe these findings in more detail below. Section B provides context for the findings.

1. Pilot implementation

For most of the grantees, it was about 10 to 12 months from the time the grants were awarded to the start of pilot enrollment. The amount of work required during this period was significant, and most grantees faced challenges with developing partnerships and contracting, identifying and hiring qualified staff, and developing certain new activities. However, all grantees were able to begin pilot enrollment with most services in place. Overall, the models generally were implemented as intended, with some changes made over time in response to emerging needs. Once the pilots began, most pilots faced challenges related to recruiting individuals and engaging those enrolled in specific activities, such as occupational skills training and work-based learning. Some also identified gaps in the types or amounts of support services available to meet the needs of individuals in the pilot. Many of these challenges may have affected how the pilots were implemented and outcomes of the individuals who enrolled. In many cases, grantees were able to implement changes to their policies or procedures to address these challenges, but some issues persisted.

2. Participation in pilot services among treatment group members

With the exception of one pilot, nearly 70 percent or more of treatment group members started pilot intake, assessments, or an employment or training-related activity after random assignment; in more than half of the pilots, initial engagement rates were more than 80 percent. Although initial engagement rates were high, the rates at which treatment group members ultimately started an employment or training-related activity after they completed intake and assessments were lower; in seven pilots, less than 70 percent of treatment group members started an activity. Job search/readiness assistance or training had the highest take-up rates across pilots—60 percent or more of individuals in several pilots. Fewer individuals participated in the other activities—usually less than 25 percent.

Although not all treatment group members participated in activities, most did receive case management and support services while engaged in the pilot. More than 90 percent of individuals in seven pilots had at least one contact with a case manager. The percentage of individuals who received at least one support service varied much more across the pilots, but generally 50 to 80 percent of treatment group members received a support service while in the pilot—most commonly transportation assistance.

In six pilots, 30 percent or more of treatment group members exited the pilot within the first three months after random assignment, and between 50 to 80 percent exited by the sixth month. In the other four pilots—California, Kansas, Kentucky, and Vermont—individuals remained in the pilot much longer, with many still in the pilot at 12 months. Across all pilots, most individuals exited before completing all activities or they became ineligible for the pilot due to losing SNAP eligibility, receiving TANF, or not complying with pilot rules and being terminated. In most pilots, fewer than one-third of individuals exited the pilot due to completing all pilot activities or finding employment (based on self-reporting).

3. Differences between treatment and control groups in service receipt

Treatment group members in all pilots were more likely than control group members to participate in job search training or assistance activities and education or training activities. They were also generally more likely to participate in specific components of education or training activities, including general job skills training, occupational skills training, education, and work-based learning activities. For each pilot, treatment group members were more likely than control group members to complete education and training activities; for all pilots except California (ES), they also were more likely than control group members to receive occupational certificates or licenses.

In 8 of the 10 pilots, treatment group members received case management at higher rates than control group members and had more case management contacts on average. Treatment group members were also more likely to receive support services overall and specific types of support services, such as transportation assistance, and support for work items, such as uniforms, boots, clothes, or tools.

4. Impacts of pilot services on individuals' outcomes

The enhanced services offered to treatment group members led to an increase in earnings in the two-year period (Years 2 and 3) in 3 pilots (California (NS), Mississippi, and Virginia) but had no effect in the other 7 pilots. In all 10 pilots, both treatment and control group members experienced increases in average earnings over time. Increases in earnings ranged from about $2,000 to $4,000 over the two-year period.

These increases in earnings generally did not translate into reductions in SNAP participation, but some pilots did have an impact on participation. The availability of treatment group services decreased the

likelihood of SNAP participation by 3 percentage points in Illinois and increased it in two pilots (Mississippi and Virginia) by 2 to 4 percentage points.

Notably, in five pilots (California, compared to the no service control group; Illinois; Kansas; Kentucky; and Vermont), treatment group services increased employment over the two-year period. Increases in employment ranged from 4 to 6 percentage points. Out of the five pilots that had impacts on employment, four (all except California [NS]) did not have a corresponding impact on earnings.

The increase in earnings translated into reductions in food insecurity in California (NS) and in very low food security in California (NS) and Mississippi (BCCS). There were no other impacts on food security status.

5. Pilot costs and cost-benefit analyses

The total costs of the pilots—including those for the planning period, recruiting treatment and control group members, and providing treatment group services—ranged from $6,813,186 in Georgia to $23,362,819 in Washington. The cost-benefit analysis compared the benefits individuals received through earnings and public assistance with the average costs of all services and activities treatment and control group members received per individual through the pilots, existing SNAP E&T programs, or the community. The costs of all services and activities treatment group members received were generally about 25 percent higher than those of pilot services alone (between about $2,000 and $9,000 per individual, on average), suggesting that treatment group members received some services from existing SNAP E&T or community resources. The costs of all services and activities control group members received through existing SNAP E&T programs or the community (between about $1,000 and $3,000 per individual, on average) were less than a third of the costs for treatment group members.

We examined treatment group benefits and costs relative to the control group from multiple perspectives, including those of (1) individuals enrolled in the treatment groups, (2) government and taxpayers, and (3) society as a whole. The latter represents the sum of the other two perspectives. The net benefits of treatment group services generally were negative for society during the 36-month follow-up period according to UI wage records and 36-month follow-up survey data (by $400 to $6,000 per individual across pilots and data sources). Several pilots had positive net benefits to society, including Mississippi (by about $300 for each the ECCS and BCCS group according to UI wage records) and Georgia (by about $100, according to survey data). Treatment group services generally led to a net benefit for individuals in most pilots due to higher earnings and receipt of support services (about $100 to $5,000 per individual across pilots and data sources). However, the services and activities that treatment group members received generally resulted in a larger cost to government and taxpayers (about $1,000 to $6,000 per individual), compared to the benefits. The benefits did not offset the costs of the services, on average, during the 36-month follow-up period.

B. Placing findings in the context of the workforce evaluation literature

The study findings are consistent with the previous literature that has often found small or no labor market effects of employment and training programs for low-income populations offering similar services as the pilots. Comprehensive literature reviews are provided in Barnow and Smith (2015), Card et al. (2017), Vollmer et al. (2017), and Goger et al. (2020). This literature covers a range of employment and training activities and support services offered by both ongoing programs as well as grant programs similar to the pilots, using impact designs with rigorous control (or comparison) groups.

The literature suggests that programs serving low-income populations can typically engage individuals and increase their receipt of services relative to those received by the study control groups in their local areas. These differences can be large, especially for the receipt of occupational skills training and subsidized employment, translating into positive effects on the percentages of individuals who participate in training activities and the attainment of associated certificates and credentials. However, few of the studies have found that the programs lead to long-term increases in earnings or independence from public assistance (at least over the time period covered by the studies, which is typically less than four years).

There are notable exceptions in the literature, however, that show the types of services offered by the pilots could be effective in improving labor market outcomes. McConnell et al. (2021) found using a randomized control trial and nationally representative samples of adults and dislocated workers that having access to WIOA intensive services—one-on-one staff assistance such as assessments, coaching, career counseling, and service referrals—increased earnings by about 15 percent over a three-year follow-up period and yielded benefits that exceeded costs from the perspective of society. This evaluation, however, found no earnings effects of WIOA-funded occupation skills training. Further, several reviews of the existing literature on the role of supportive services in employment and training programs suggest that low-income populations receiving supportive services, in combination with technical training and other ancillary services, such as case management, can have more positive employment and earnings outcomes compared to groups that do not receive such wraparound services (Davis et al. 2013; Gueron and Hamilton 2002; Maguire et al. 2010; U.S. Department of Labor, U.S. Department of Commerce, U.S. Department of Education, U.S. Department of Health and Human Services 2014). Another notable exception is the random assignment evaluation of STEP Forward (Walter et al. 2017) based on a diverse group of low-income job seekers, many of whom received CalWORKs (California's TANF program) benefits, had exhausted their unemployment insurance benefits, or received benefits from CalFresh (California's SNAP). The study found that the impacts of subsidized employment offered to the treatment group continued into the fourth year, well after the subsidies had ended. Similarly, Reed et al. (2012) found statistically significant positive impacts of registered apprenticeships, even nine years after program entry.

The literature also suggests that interventions that *combine* several strategies to help low-income individuals find and keep jobs appear more effective than any *single* strategy (Vollmer et al. 2017). Further, "meta-analyses"—that use regressions to combine and analyze impacts from different studies—find that total program effects are more than the sum of the effects of each of the program's strategies (Vollmer et al. 2017). Thus, implementation and other factors that affect how well multiple components of a program are operationalized and delivered are crucial determinants of a program's success. Relatedly, the literature has consistently found considerable diversity in program impacts across individuals (females and the long-term unemployed tend to experience larger benefits) and across labor market conditions (programs are less likely to show positive effects during periods of economic growth), but the patterns are not always consistent across studies (Card et al. [2017]; Barnow and Smith [2015]).

Overall, the observed increases in the rates of take-up and completion of pilot activities and receipt of services, and the earning impacts found in some, but not all, pilots fit within the broader related literature. Although comparing the findings in this evaluation to those in the literature is informative, it is important to consider that differences in target populations, local economies, and varied experiences in implementing activities and services available in a pilot or program make it challenging to form direct comparisons to other studies. The next section provides context for the evaluation findings from this perspective.

C. Discussion

The enhanced services offered to treatment group members increased earnings in three pilots. In both these pilots and the seven without impacts on earnings, the enhanced services increased the percentages of individuals who received case management and support services relative to the control group, as well as the percentage of those who participated in employment or training-related activities. These accomplishments are notable, given the prevalence and extent of barriers many treatment group members faced—across all pilots, only 5 to 28 percent of individuals were employed at the time of random assignment, and 19 to 30 percent did not have a high school diploma. The higher rates of receipt of case management and support services among treatment group members in some pilots, particularly transportation assistance, may have allowed them to overcome barriers associated not only with starting employment or training-related activities, but also sustaining participation over time and ultimately completing those activities. Indeed, in many pilots, treatment group members participated for a greater number of months and a greater number of hours per week than the control group, and achieved higher completion rates.

1. Discussion of pilots with impacts on earnings

The presence of impacts on earnings in California (NS), Mississippi, and Virginia likely reflects the following factors:

- **The enhanced set of services led to the largest increases in the percentage of individuals who participated in employment or training-related activities relative to the control group.** These pilots had the largest differences between treatment and control groups in the rate of participation in education or training-related activities. The differences were 31 percentage points in California and Mississippi (ECCS), 24 percentage points in Mississippi (BCCS), and 23 percentage points in Virginia, compared with an average of 14 percentage points in the other pilots. In California and Mississippi in particular, treatment group services nearly doubled the percentage of individuals who participated in these activities compared to control group members.
- **The enhanced set of services led to the largest differences between treatment and control groups in the rate of completion of education or training-related activities.** The differences were about 26 percentage points in Mississippi (ECCS), 23 percentage points in California (NS), and 21 percentage points in Virginia, compared with an average of 11 percentage points in the other pilots. In California and Mississippi (ECCS), treatment group services more than doubled the rate of completion of activities relative to the control group and, in all three pilots, either nearly or more than doubled the rate of receipt of occupational certificates or licenses.
- **The enhanced set of services led to some of the largest differences between treatment and control groups in the receipt of case management or support services.** In California, treatment group services almost tripled the rate of receipt of case management relative to the NS control group and increased the rate of receipt of support services, although this increase was not as large. In Mississippi and Virginia, treatment group services nearly doubled the percentage of individuals who received transportation assistance. Higher rates of case management and support services in these pilots, especially transportation assistance, may have allowed individuals to overcome barriers associated not only with starting employment or training-related activities, but also sustaining participation over time and ultimately completing those activities.

Context for pilots with impacts on earnings. The positive findings in California are not entirely surprising given the control group was not offered any existing SNAP E&T program services and had to seek out services in the community on their own. Unlike some other pilots that provided control group services at the same location where individuals were enrolled, California did not. The control group was enrolled by SNAP eligibility staff (not by a provider) and therefore had to learn about and seek out services that were available in the community on their own, if they wanted them. This likely contributed to the large differences in participation and completion of activities between the CBA and NS control group in California.

In Mississippi and Virginia, the process for offering services may have led to less drop off and increased participation in and completion of activities. Both pilots primarily offered all of their services and activities at one set of locations—community colleges. Although there often was drop off between enrollment and individuals first going to the community college (SNAP agencies conducted pilot enrollment and referred individuals to the community college), once there, the community college provided case management, support services, training, adult education, and work-based learning opportunities (in Mississippi). Treatment group members did not have to work with multiple providers or receive referrals to other locations to obtain the full package of services. This "one-stop" type of provider may have contributed to treatment group members staying in services and participating in activities at higher rates than the control groups who likely would have had to work with multiple providers to obtain similar services.

2. Discussion of pilots with no impacts on earnings

The lack of an impact on earnings in the remaining pilots may reflect a range of potential factors:

- **In Delaware, Georgia, Kentucky, and Washington, only 40 to 56 percent of treatment group members started an employment or training-related activity, which was lower than expected.** The fact that one-third to more than half of treatment group members in these pilots did not participate in a substantive activity could have diluted the impacts on outcomes such as earnings.
- **In Illinois, despite not having an impact on earnings in Years 2 and 3, the rate of participation in employment and training-related activities and the differences between research groups in rates of participation and completion were similar to those in pilots that had impacts.** An impact on earnings did emerge in Year 3, however, possibly reflecting that Illinois had the largest percentage of individuals participating in occupational skills training across the pilots. Engagement in training activities likely reduced the chances of moving into higher-paying jobs during part of the pilot period, making it less likely to observe an impact on earnings in the two-year period.
- **In Vermont and Kansas, many treatment group members started an employment or training-related activity, but differences between treatment and control groups in participation and completion of activities were small.** In addition, Vermont served SNAP participants with severe barriers to employment, but the treatment group was only slightly more likely than the control group to receive case management and support services.
- **Earnings impacts might have depended on the type of activities in which individuals participated.** Pilots offered individuals in the treatment groups a wide range of activities. Earnings impacts may not be apparent for all treatment group members, but that finding does not mean specific activities, such as occupational skills training or work-based learning, were ineffective.

Context for pilots with increased employment but no impact on earnings. Although none of these pilots' services resulted in an impact on earnings, some—Illinois, Kansas, Kentucky, and Vermont—did increase employment. There is not one consistent reason why these pilots were able to increase employment but had no impact on earnings. Instead, each site had its own implementation and environmental factors that affected the findings. For example, Kansas had delays in establishing occupational skills training and ultimately had limited training options. This resulted in less than one-quarter of treatment group members participating in training and over 70 percent of them participating primarily in job-readiness activities and independent job search. As a result, many treatment group members became employed, but many may not have had the skills, education, or certifications that could lead to higher-paying jobs. This likely resulting in no impacts on earnings. Similarly, Illinois faced difficulty in matching individuals with appropriate providers and activities, particularly early in the pilot. Although Illinois took steps to address this, it often resulted in individuals failing to remain in and complete substantive activities, such as occupational skills training. Although a relatively large number of treatment group members started occupational skills training, only about half of those completed it, while many individuals participated in and completed job search or job search training.

In Kentucky, the economic conditions likely played a significant role in the lack of impacts on earnings. Historically, the area has relied heavily on the coal mining industry, which has declined dramatically over the last decade. What was left were mainly retail, food industry, or other low- or minimum-wage jobs. Therefore, even when individuals completed training or obtained work experience, there were few employment opportunities available to them. They could find a job—most employers in the area needed employees—but it was unlikely they could earn much more than minimum wage, even when they had training.

Although all pilots served individuals with barriers to employment, Vermont focused on those with severe barriers. The pilot model emphasized case management and support services, with activities being offered after individuals had reduced their barriers enough to begin to build their skills. Pilot staff discussed the difficulty of overcoming barriers related to transportation, substance use, mental health, criminal histories, and homelessness. Because of this, many individuals were not ready for employment or were severely constrained in the types of employment for which they could apply. The amount of time required to reduce severe barriers, become employed, and obtain higher-paying jobs may reflect why the pilot showed a higher rate of employment for the treatment group but not higher average earnings. With many treatment group members participating in activities in Year 3 and employment impacts just beginning to emerge in that year, a greater amount of time may be required in which to observe earnings impacts among such a highly-barriered population.

Context for pilots with no employment or earnings impacts. Three pilots—Delaware, Georgia, and Washington—did not result in impacts on employment or earnings. A range of implementation issues likely contributed to these findings. For example, in Delaware, the lack of an impact may reflect that only 40 percent of treatment group members started an employment or training-related activity, meaning nearly two-thirds did not participate in a substantive activity. Delaware also struggled to consistently and fully offer two of their three industry-specific tracks throughout the pilot period, and only about 100 people were enrolled in each of those tracks. Thus most of the treatment group did not participate in the industry-specific tracks and received primarily job placement services (support with developing resumes, preparing for job interviews, and offering job leads), where they generally did not develop new skills. These activities were similar to those received by the control group. The treatment group members likely were receiving more intensive case management and general support in obtaining jobs, but the percentage

of them becoming employed, and the wages for those jobs, may not have been much different from what was available to the control group.

Similarly, Georgia faced implementation challenges that limited overall engagement and skill building, which likely contributed to finding no impacts on employment or earnings. First, individuals were enrolled in the pilot by one agency, then referred to another for orientation and upfront job search training. Having multiple referral points can create opportunities for people to drop out of the program, and, in fact, over 40 percent of the treatment group never attended an orientation after enrollment. Second, Georgia required that individuals participate in job search training activities before being referred to education or occupational skills training (which was offered by another provider at a different location). Staff suggested that some individuals likely left the program before being offered education and training; some treatment group members suggested that the training options available were not geared towards their needs or interests. These factors likely contributed to only about 6 percent of the treatment group participating in occupational skills training; without obtaining additional skills, individuals were less likely to obtain higher wage jobs.

Washington faced a different implementation challenge—the lack of difference in the services the treatment group and control group received. DSHS faced a unique challenge when this pilot started, as it already operated a robust SNAP E&T program in the State. DSHS had to ensure it was able to identify, develop, and implement services that were significant enhancements to what the control group could already receive for the pilot to be most likely to have an impact on individuals' outcomes. The primary differences between the pilot and the existing SNAP E&T program were offering a mandatory, upfront job readiness course, work-based learning, and more robust support services. However, less than half of treatment group members started the job readiness course and fewer completed it. Virtually no one started work-based learning, and support services were offered inconsistently across providers. Therefore, many treatment group members did not receive the services or participate in the activities that were the main differentiators between the pilot and the existing SNAP E&T program, which resulted in small differences in overall rates of participation in education or training-related activities between research groups. This suggests that having a robust existing SNAP E&T program, created less room for substantial improvement in take-up and completion of activities through RISE and likely contributed to the lack of impacts.

3. Discussion of impacts on SNAP participation

The findings related to SNAP participation generally make sense, given the patterns of changes in earnings for treatment and control group members. Conceptually, SNAP E&T services are designed to increase individuals' earnings and thus reduce their need for SNAP or other public assistance. Pilots without an impact on earnings also generally did not show an effect on SNAP participation. Illinois was an exception; treatment group services did not lead to an increase in earnings over the two-year period (Years 2 and 3) but did lead to a decrease in SNAP participation. Among the pilots without an impact on earnings in the two-year period, Illinois had the second-to-largest difference between research groups in participation in employment or training-related activities and the largest difference in the rate of completion of these activities. It also had higher rates of participation in activities for all three years following random assignment, which was relatively uncommon across the pilots. This higher rate led to an increase in earnings in Year 3, but not Years 2 and 3 combined, which likely translated into a reduced need for SNAP. In addition, because most of the individuals enrolled in the pilot in Illinois were mandatory work registrants, the reduction in SNAP participation rates may be related to the sanctioning of individuals who did not engage in pilot services.

In Mississippi (BCCS) and Virginia, although the treatment group services led to increased earnings, this increase did not result in reduced participation in SNAP. It is possible that the increase in earnings partly reduced SNAP benefit amounts as a percentage of the maximum benefit but the increase was not large enough to make individuals ineligible to receive SNAP. It is also possible that the increase in earnings did reduce the likelihood of participating in SNAP, but this reduction was offset by some treatment group members being more likely to continue participating in SNAP because of the education and training activities provided as part of treatment group services. In Mississippi, some individuals may have also continued to participate in SNAP because the pilot services addressing barriers to employment would be discontinued if they did not.

4. Discussion of costs relative to benefits

With the exception of two pilots (Mississippi and Georgia), the net benefit of the pilots was negative. Despite having a positive impact on earnings in California (NS) and Virginia, the increase in earnings was not large enough to offset the costs of the pilot. The seven pilots without an impact on earnings mostly had a negative net benefit as well.[28] The absence of an impact on earnings is one of several reasons why the net benefit was negative, but it primarily reflects the differential costs of treatment group services, which were not offset by the benefits accrued through earnings and fringe benefits during the 36-month follow-up period. When interpreting this finding, it is important to consider that these enhanced services were new and experimental. The purpose of the SNAP E&T pilot was to test new approaches to providing employment and training-related activities. Even though we excluded the costs of planning and recruitment in considering the cost differential between treatment and control group services, the costs of the former were likely higher for the three years the pilot operated than they would have been if these services had been provided over a longer period of time. In addition, the estimated net benefits reflect the effect of treatment group services for the average treatment group member compared to the average control group member. These averages include all individuals who enrolled, regardless of whether they ultimately participated in services. It is possible that limiting the cost-benefit analysis to individuals who in fact took up services might result in showing the benefits of treatment group services exceeding the costs from all perspectives, even if the costs of services for those who engaged were higher.

5. Future analyses and what SNAP E&T administrators can learn from the pilots

Based on these evaluation findings, there are several options for future analyses to delve more deeply into activity and employment barriers, the effectiveness of specific types of activities, and the effects of the pandemic. They include the following:

- **Learning more about the barriers to starting employment or training-related activities would help identify which case management and support services could promote greater participation in activities.** This information would help program staff adapt the content or delivery of employment and training-related activities in ways that might increase participation and lead to greater impacts. It would be particularly important in pilots that targeted highly barriered populations and focused their program model on specific types of support services but ultimately did not achieve a meaningful difference in receipt of support services between research groups.

[28] In Georgia, a relatively small and statistically insignificant impact on earnings is one of several reasons why the net benefit varied according to the source of earnings estimates—the net benefit was positive according to one data source and negative according to the other.

- **Learning more about the barriers to employment that individuals who completed employment or training-related activities faced would enhance our understanding of why their completion in some pilots did not lead to impacts on earnings.** Additional analyses also should explore whether receiving participation certificates, diplomas, degrees, or occupational licenses can affect differentially the prospect of employment for treatment group members.
- **Assessing the effectiveness of activities separately and in different combinations would help identify promising practices for improving outcomes.** Because many treatment group members participated in multiple activities, isolating the effect of a single type of activity would be challenging, however.

Although outcomes for the pilots were mixed, SNAP E&T program administrators can learn from the implementation of all of the pilots. Using information collected from grantees, partners, providers, and individuals who received pilot services, several key lessons emerged across the pilots, including the following:

- **A longer up-front time frame for planning and piloting, and a slower rollout was important for implementing major program changes.** Almost universally, grantees, partners, and providers discussed the need for a much longer planning period and a slower rollout of the pilots. Most grantees had about a year to plan their pilots, but many were making major changes or creating programs that had not existed previously, which took much longer than anticipated. Staff from several pilots did not think it was realistic to develop and start a new program within a year and suggested that if they could start over, they would roll out the pilot more slowly over several years. Some staff also discussed initially implementing the pilot in one county or region and then taking what they learned from that experience and adapting implementation in additional counties or regions.
- **Effective marketing and recruitment required planning and identifying staff with strong skills to conduct outreach.** Most grantees and their providers were not accustomed to recruiting individuals to participate in existing SNAP E&T programs. Generally, these providers serve whoever voluntarily comes through their doors, so staff do not have to seek out participants to fill their programs. For the pilots, staff needed to enroll many more individuals than they typically served, which required extensive outreach and active recruitment. Effective marketing and recruitment required planning and identifying staff who had an interest in conducting outreach and the skills to do so effectively.
- **Strategic partnering was important for most pilots, but clear and consistent communication between all organizations was important for managing partnerships.** Many pilot staff cited collaboration with partners and providers as one of their major accomplishments but also one of their biggest challenges. Partnerships were important because partners and providers performed important functions, such as conducting outreach, providing direct pilot services, and helping to administer or oversee specific aspects of the pilots. Most pilots found their partnerships with new organizations beneficial and suggested they would maintain and grow them long after the pilot ended. At the same time, building relationships presented challenges, which often related to a lack of clear communication. Some pilots worked to formalize communication by holding regular meetings with all organizations and providing written documentation detailing changes in policies or procedures.
- **Aligning policies, missions, and cultures across organizations was challenging but critical for serving the SNAP E&T population as intended.** Bringing together a diverse set of partners and providers to serve SNAP participants was not an easy task. Each came with its own deeply ingrained policies, procedures, and cultures that needed to be woven together to serve individuals in the pilots.

Grantees found this effort challenging, but they worked to create a cohesive package of pilot services that was delivered consistently across providers and locations.

- **Some providers were not prepared to address the extensive barriers that many individuals in the pilot faced.** Some of the pilots formally targeted individuals with barriers, but most providers did not anticipate that individuals would face as many barriers as they did. The depth of these barriers was surprising to many providers and often more pervasive than those in the populations they typically served. Although it is not possible to anticipate every potential need, it is important to know the needs, interests, and barriers of the target population and design a program with them in mind.
- **Customizing services to an individual's needs was important for keeping them engaged.** Conducting assessments with each individual up front was key to determining their needs and matching them with the most appropriate provider. Grantees found that not everyone needed or wanted the same set of pilot services, so providing options that could meet individuals' specific needs was beneficial. They also found it hard to anticipate what would attract individuals to the pilot. Many grantees and providers were excited about the levels and types of training opportunities they were offering, but many treatment group members came to the pilot in crisis and only wanted to find a job and pay their bills. They found it hard to focus on training, which could last for several weeks or months, without a paycheck.
- **The service model may have affected rates of take-up and completion of activities, so being flexible and addressing issues quickly was important.** After implementing the planned models, several of the pilots realized their model was not working as planned and was affecting how individuals engaged in activities. Reasons for this issue varied across the pilots. In some pilots, the model had multiple "hand-off" points or up-front requirements before individuals could enter employment, education, and training activities. In other cases, the model did not account for the flow of individuals into the pilot versus the timing of activities, which sometimes led to lengthy waiting periods before individuals could start education or training activities. As a result, individuals sometimes took up activities at different rates than expected, did not progress through the model as it was originally designed, or left it before completing activities
- **Robust support services, particularly transportation assistance, were key to getting individuals into activities and keeping them engaged.** All of the pilots offered support services, but their level and availability varied. Some pilot staff underestimated the level of supports needed to mitigate the barriers that individuals faced. Several of the pilots increased the level of support services individuals could receive over the course of the pilot. Despite the importance and wide use of support services, most pilots still faced challenges in helping individuals mitigate significant barriers that the support services could not fully address. These barriers were most often related to transportation and housing.

Although the SNAP E&T pilots have ended, the lessons learned are beneficial for the current SNAP E&T program administrators and providers as well as other workforce agencies serving similar populations. As many States are focused on program improvement, by expanding services and forming new partnerships, they likely will encounter many of the same issues that emerged in the pilots. The pilots showed that coordinated outreach and recruitment is important for connecting SNAP E&T participants with services even when intensive services and robust activities are offered. It is also critical that States are able to connect individuals with support services to reduce their barriers to participation. In addition, anticipating the amount of time, effort, and staff needed for coordination and planning when onboarding new partners, understanding the complexity of developing and implementing new activities in the program, and identifying obstacles to take-up rates prior to implementation also can help administrators avoid pitfalls.

As challenges are encountered, administrators and providers need to be flexible and make adjustments to resolve these problems and maximize the effectiveness and reach of their programs.

References

Barnow, B.S., and J. Smith. "Employment and Training Programs." In Economics of Means-Tested Transfer Programs in the United States, Vol. II, edited by R.A. Moffitt. Chicago, IL: University of Chicago Press, 2015, pp. 127–234.

Card, David, Jochen Kluve, and Andrea Weber. "What Works? A Meta Analysis of Recent Active Labor Market Program Evaluations." Journal of the European Economic Association, vol. 16, no. 3, 2018, pp. 894–931.

Davis, L.M., R. Bozick, J.L. Steele, J. Saunders, and Jeremy N.V. Miles. "Evaluating the Effectiveness of Correctional Education: A Meta-Analysis of Programs That Provide Education to Incarcerated Adults." Santa Monica, CA: RAND Corporation, 2013.

Dotter, Dallas, Kelley Monzella, James Mabli, Barbara Carlson, Julie Hartnack, Peter Schochet, Mason DeCamillis, Dan Thal, Leah Shiferaw, Amy Defnet, Nora Paxton, and Stephen Freedman. "Expanding Opportunities and& Reducing Barriers to Work: Final Report Technical Supplement." Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service, 2022. Available at https://www.fns.usda.gov/research-analysis.

Goger, Annelies, Mikia Manley, Jonah Deutsch, Melissa Mack, Kate Dunham, and Peter Schochet. "The Trade Adjustment Assistance Program: An Evidence Scan of Services and Innovations." Report submitted to the Chief Evaluation Office, U.S. Department of Labor. Washington, DC: Mathematica, September 2020.

Gueron, Judith M., and Gayle Hamilton. "The Role of Education and Training in Welfare Reform." Welfare Reform and Beyond Policy Brief No. 20. Washington, DC: Brookings Institution, 2002.

Maguire, S., J. Freely, C. Clymer, M. Conway, and D. Schwartz. "Tuning In to Local Labor Markets: Findings from the Sectoral Employment Impact Study." Philadelphia, PA: Public/Private Ventures, 2010.

McConnell, Sheena, Peter Z. Schochet, Dana Rotz, Ken Fortson, Paul Burkander, and Annalisa Mastri. "The Effects of Assistance from Employment Counselors Provided by the Adult and Dislocated Worker Programs: Findings from a Nationally Representative Randomized Controlled Trial." Journal of Policy Analysis and Management, April 2021. https://doi.org/10.1002/pam.22305.

Reed, Debbie, Albert Y. Liu, Rebecca Kleinman, Annalisa Mastri, Davin Reed, Samina Sattar, and Jessica Ziegler. "An Effectiveness Assessment and Cost-Benefit Analysis of Registered Apprenticeship." Report for the U.S. Department of Labor Employment and Training Administration. Princeton, NJ: Mathematica Policy Research, July 2012.

U.S. Department of Labor, U.S. Department of Commerce, U.S. Department of Education, and U.S. Department of Health and Human Services. "What Works in Job Training: A Synthesis of the Evidence." Washington, DC: U.S. Departments of Labor, U.S. Department of Commerce, U.S. Department of Education, and U.S. Department of Health and Human Services, 2014.

Vollmer, L., A. Mastri, A. Maccarone, and E. Sama-Miller. "The Right Tool for the Job: A Meta-Regression of Employment Strategies' Effects on Different Outcomes." Washington, DC: Mathematica Policy Research, 2017.

Walter, Johanna, David Navarro, Chloe Anderson, and Ada Tso. "Testing Rapid Connections to Subsidized Private Sector Jobs for Low-Income Individuals in San Francisco: Implementation and Early Impacts of the STEP Forward Program." OPRE Report #2017-103. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2017.

Appendix A. Data sources

Appendix Table A.1. Implementation Site Visit Dates, Cohorts, and Follow-Up Periods, by Data Source[a]

Grantee	3 rounds of implementation site visit dates	Administrative service use data cohorts	36-month survey data cohorts[b]	UI wage records cohorts	SNAP administrative data cohorts	Cost data[c]
Follow-up period		From random assignment to pilot closeout	36 months	12 quarters	36 months	
CA	July 2016 June 2017 September 2018	01/2016 – 06/2017	01/2016 – 06/2017	01/2016 – 06/2017	01/2016 – 06/2017	Costs from 04/2015 – 12/2018
DE	July 2016 June 2017 October 2018	02/2016 – 08/2018	02/2016 – 12/2017	02/2016 – 09/2017	02/2016 – 12/2017	Costs from 04/2015 – 12/2018
GA	July 2016 June 2017 September 2018	02/2016 – 02/2018	02/2016 – 12/2017	02/ 2016 – 09/2017	02/2016 – 12/2017	Costs from 04/2015 – 01/2019
IL	August 2016 May 2017 September and October 2018	03/2016 – 09/2017	03/2016 – 09/2017	03/ 2016 – 09/2017	03/2016 – 10/2017	Costs from 04/2015 – 02/2019
KS	June 2016 June 2017 October 2018	01/2016 – 01/2018	01/2016 – 12/2017	01/2016 – 09/2017	01/2016 – 12/2017	Costs from 04/2015 – 03/2019
KY	September 2016 July 2017 November 2018	04/ 2016 – 08/2018	04/2016 – 12/2017	04/2016 – 09/2017	04/2016 – 12/2017	Costs from 07/2015 – 04/2019
MS	August 2016 June 2017 September 2018	03/2016 – 09/2018	03/2016 – 12/2017	03/2016 – 09/2017	03/2016 – 12/2017	Costs from 04/2015 – 02/2019
VT	August 2016 May 2017 September 2018	03/2016 – 04/2018	03/2016 – 12/2017	03/2016 – 09/2017	03/2016 – 12/2017	Costs from 04/2015 – 12/2018

Appendix Table A.1. Implementation Site Visit Dates, Cohorts, and Follow-Up Periods, by Data Source[a] *(continued)*

Grantee	3 rounds of implementation site visit dates	Administrative service use data cohorts	36-month survey data cohorts[b]	UI wage records cohorts	SNAP administrative data cohorts	Cost data[c]
Follow-up period		**From random assignment to pilot closeout**	**36 months**	**12 quarters**	**36 months**	
VA	July 2016 June 2017 October 2018	03/2016 – 06/2018	03/2016 – 12/2017	03/2016 – 09/2017	03/2016 – 12/2017	Costs from 03/2015 – 12/2018
WA	June 2016 June 2017 November 2018	02/2016 – 03/2018	02/2016 – 12/2017	02/2016 – 12/2017	02/2016 – 12/2017	Costs from 04/2015 – 12/2018
	Implementation site visit data were used to describe the flow of services and how they changed over time, the challenges staff faced, and lessons learned.	Administrative service use data summarized treatment group members' engagement in and participation in services and activities offered through the pilot.	12-month survey data was used to describe differences in service receipt between research groups and to estimate impacts on individuals' outcomes, including earnings, employment, food security, and well-being.	UI wage records were used to estimate impacts on earnings and employment.	SNAP administrative data were used to estimate impacts on participation in SNAP, TANF, and Medicaid and related benefit amounts for SNAP and TANF.	Cost data were used to estimate the costs of services and activities provided through the pilot and to compare the costs and benefits of services and activities across research groups.

Source: SNAP employment and training evaluation data.

Notes: UI wage data are also available for the two years before random assignment for each individual. SNAP administrative data are also available for the one year before random assignment for each individual.

[a]"Cohort" indicates the dates in which individuals were randomly assigned.

[b]Data available for individuals enrolled in the pilot who responded to the 12-month follow-up and 36-month follow-up surveys.

[c]Cost data start with the earliest planning period month in each pilot

Appendix Table A.2. Number of treatment and control group members, by data source

	Administrative service use data	36-month survey data		UI wage records		SNAP administrative data	
Pilot	Treatment group	Treatment group	Control group	Treatment group	Control group	Treatment group	Control group
CA (NS)	1,797	689	552	1,797	1,465	1,797	1,465
CA (ES)	1,797	689	247	1,797	633	1,797	633
DE	3,391	619	628	2,672	2,672	2,672	2,672
GA	2,483	847	796	2,291	2,305	2,291	2,305
IL	2,504	813	783	2,503	2,509	2,503	2,509
KS	2,088	613	557	1,987	1,974	1,987	1,974
KY	1,598	426	362	1,262	1,274	1,262	1,274
MS (ECCS)	1,015	268	256	737	735	737	735
MS (BCCS)	1,006	281	256	736	735	736	735
VA	2,512	779	744	1,925	1,911	1,925	1,911
VT	1,510	446	403	1,378	1,378	1,378	1,378
WA	2,548	510	481	2,235	2,231	2,235	2,231

Source: SNAP employment and training evaluation administrative service use data; SNAP employment and training evaluation 12 and 36-month surveys, SNAP employment and training evaluation UI wage records, SNAP employment and training evaluation SNAP administrative data

Notes: The numbers of treatment group members in the CA (NS) and CA (ES) rows are identical because they represent the same group of individuals. Similarly, the numbers of control group members in the MS (ECCS) and MS (BCCS) are identical because they represent the same group of individuals. Numbers of treatment and control group members in the survey data, UI wage records, and SNAP administrative data represent individuals enrolled through mid- to late-2017 (see Table A.1 for specific months), even though most pilots continued to enroll individuals in 2018.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix B. Pilot overviews

Appendix Table B.1. Description of existing SNAP E&T program services and activities and key pilot services and activities

Pilot	Existing SNAP E&T services and activities (available to the control group)	Key pilot services and activities (available to the treatment group)
California	*ES group:* • 18 months of case management • Assistance in connecting individuals to education and training • Job search assistance • Wraparound services for members of the individual's family *NS group:* • No SNAP E&T program services available	18 months of intensive case management GED preparation classes Referrals to occupational skills training or postsecondary education Subsidized employment Job search assistance Support services Financial incentives for upgrading skills and remaining in services
Delaware	Limited services and activities: • Basic case management • Job search assistance • Workfare • Job placement assistance • Small transportation stipends	Four tracks: three industry-specific skills training and employment tracks—construction, culinary, and manufacturing, with subsidized employment at KraftHeinz—and one job placement track Intensive case management Job readiness assistance Financial literacy counseling Support services, including referrals to criminal background remediation
Georgia	Limited services and activities: • Independent job search • Support services	Job search preparation and training Job search assistance Job readiness workshops Occupational skills training Work-based learning[a] Case management Support services
Illinois	No existing SNAP E&T program services were available in 18 pilot counties Limited services and activities in other counties (including Cook County): • Adult basic education and GED services • Occupational skills training where available • Unsubsidized work experience and workfare • Limited support services	Assessment and career exploration Case management Adult basic education and GED services Occupational skills training Work-based learning (paid work experience, on-the-job training, subsidized work) Job readiness and job search assistance Job retention services Support services

Appendix Table B.1. Description of existing SNAP E&T program services and activities and key pilot services and activities *(continued)*

Pilot	Existing SNAP E&T services and activities (available to the control group)	Key pilot services and activities (available to the treatment group)
Kansas	No existing SNAP E&T program services were available in the Southeast region Limited services and activities in other areas: • Limited occupational skills training • Referrals to GED services and local workforce development centers for training • Limited support services	Intensive case management Job readiness preparation Job search assistance and job development and matching Occupational skills training Soft skills, life skills, and basic education through the Bridges and Partners 4 Success (P4S) programs Mental health and substance use disorder counseling Job retention services Support services
Kentucky	Kentucky did not offer a SNAP E&T program in the pilot counties before or during the pilot period	Coordinated team-based case management Extensive support services Basic adult education Occupational skills training Work-based learning opportunities Coaching while in training or employment settings
Mississippi	Limited services and activities: • 30 days of up-front job search • Workfare • Transportation support • Tuition assistance and GED classes were available in some counties	*For the ECCS group:* • A four-week EDGE class • Three pathways—academic (basic education, postsecondary education, or occupational skills training), life skills (additional work or behavioral skills), or work (subsidized or unsubsidized employment or internships) • Support services • Intensive case management *For the BCCS group:* • Three pathways (academic, life skills, or work) • Support services • Limited case management
Vermont	Limited services and activities: • Basic case management • Job search assistance • Workfare • Job placement assistance	Clinical assessment and counseling Ongoing barrier reduction through support services Referral to employment services with a vocational rehabilitation counselor or Vermont Department of Labor case manager Classes through Community College of Vermont to obtain a Governor's Career Readiness Certificate Referrals to education or occupational skills training providers

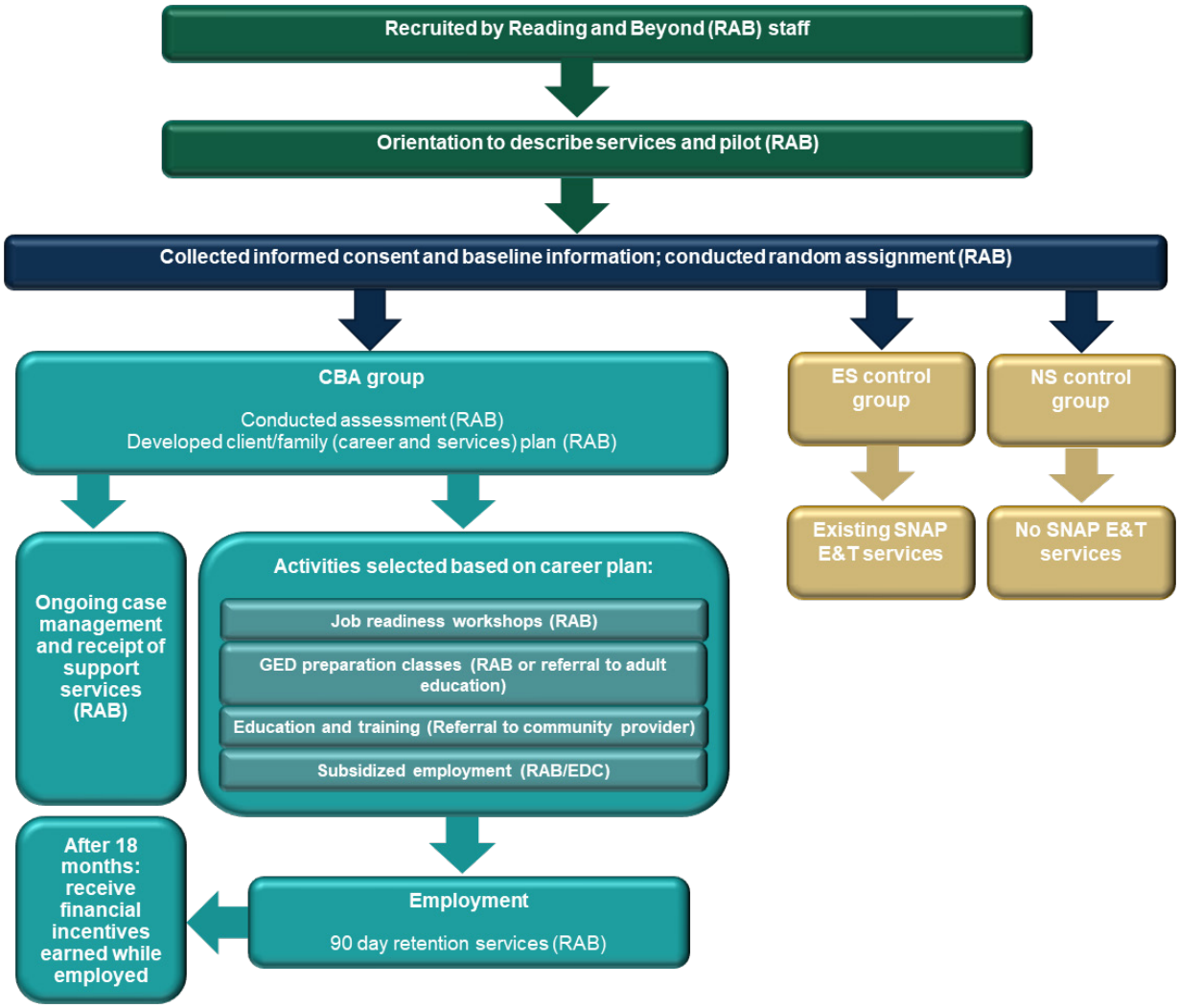
Appendix Table B.1. Description of existing SNAP E&T program services and activities and key pilot services and activities *(continued)*

Pilot	Existing SNAP E&T services and activities (available to the control group)	Key pilot services and activities (available to the treatment group)
Virginia	No existing SNAP E&T program services available in 12 localities In the other localities: • Limited case management • Job search assistance • Support services	Career counseling Intensive case management Digital literacy Job readiness training Group counseling Adult basic education and GED services Occupational skills training leading to certified credentials Extensive support services
Washington	Job readiness training Basic skills/ESL training Occupational skills training Job search assistance Job placement Support services	Comprehensive case management Extensive wraparound and support services to address barriers A mandatory six-week life skills course (Strategies for Success) Work-based learning opportunities (on-the-job training, subsidized and regular employment, and internships and externships) All available Basic Food Employment and Training services

[a] The grantee had planned to offer work-based learning, but the activity was not offered systematically across the pilot locations. Some regions offered work-based learning placements through WIOA funding to a small number of individuals.

BCCS group = basic community college services treatment group; ECCS group = existing community college services treatment group; ES group = existing services control group; ESL = English as a second language; GED = General Education Development; NS group = no services control group.

Figure B.2. California's pilot flow and pathways



Note: A complete written description of California's client flow and pilot pathways can be found in Chapter IV, Section C of the California Final Evaluation Report.

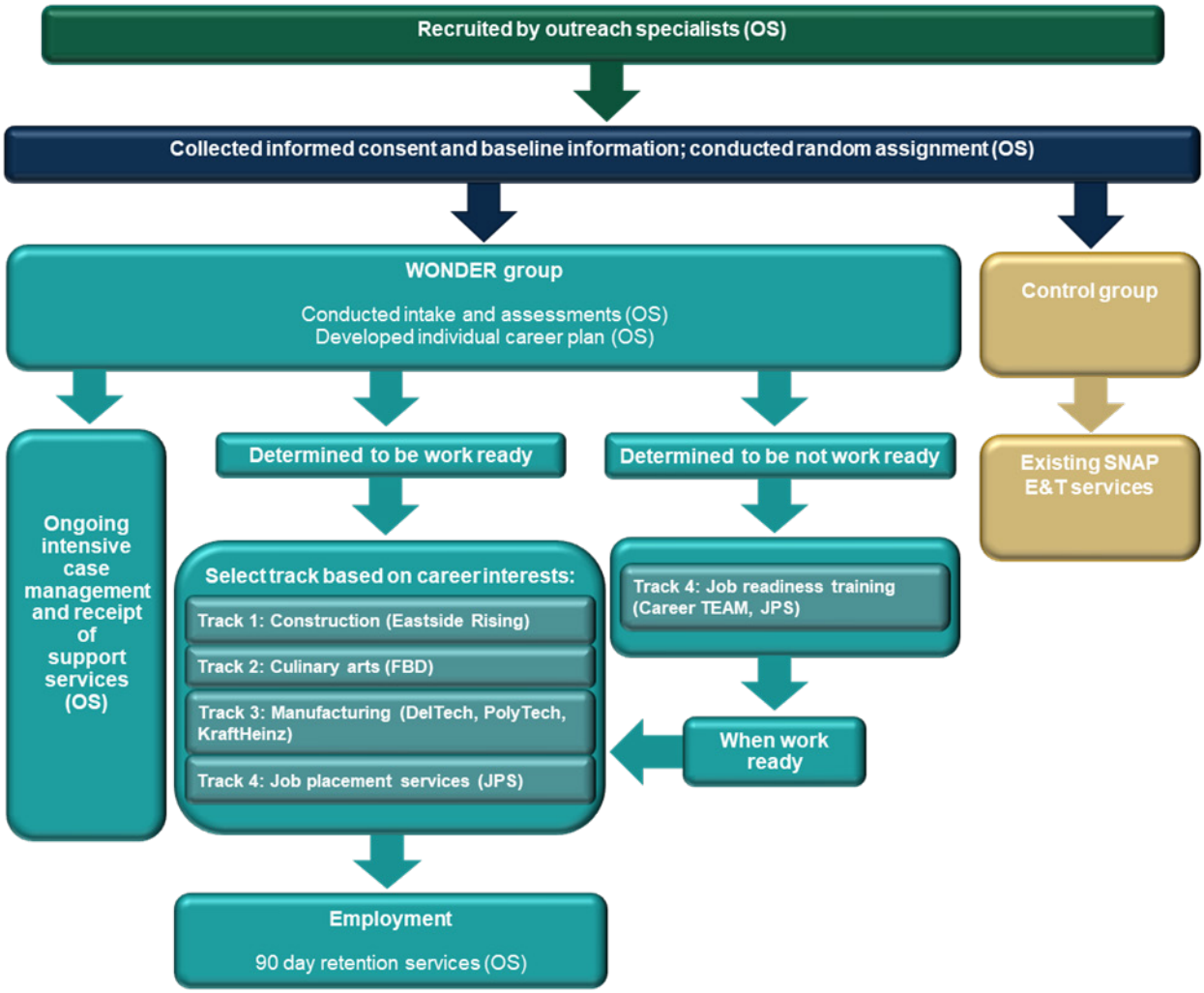
CBA = California Bridge Academy

EDC = Fresno County Economic Development Corporation

ES = existing services

NS = no services

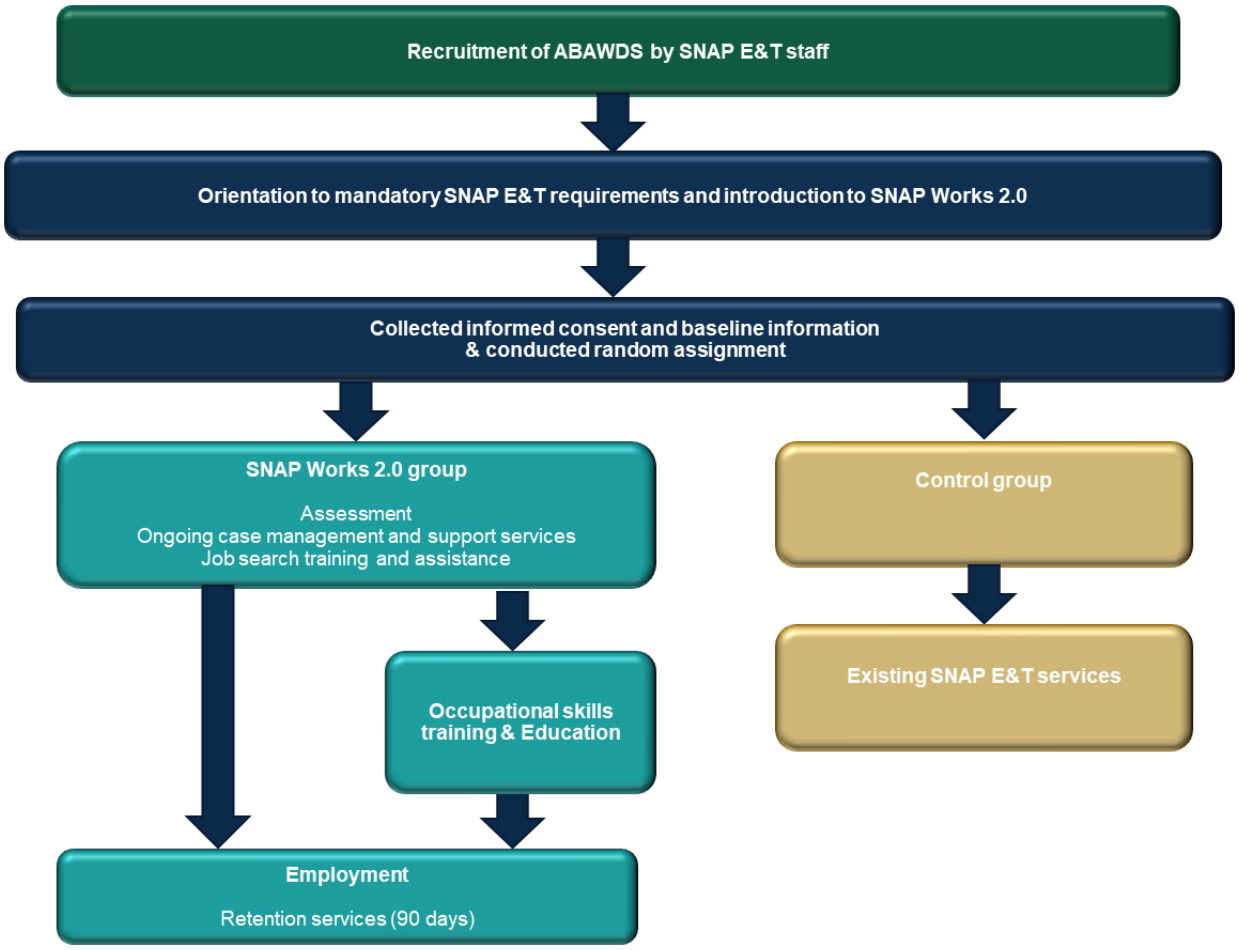
Figure B.3. Delaware's pilot client flow and pilot pathways



Note: A complete written description of Delaware's client flow and pilot pathways can be found in Chapter IV, Section C of the Delaware Final Evaluation

WONDER = Work Opportunity Networks to Develop Employment Readiness

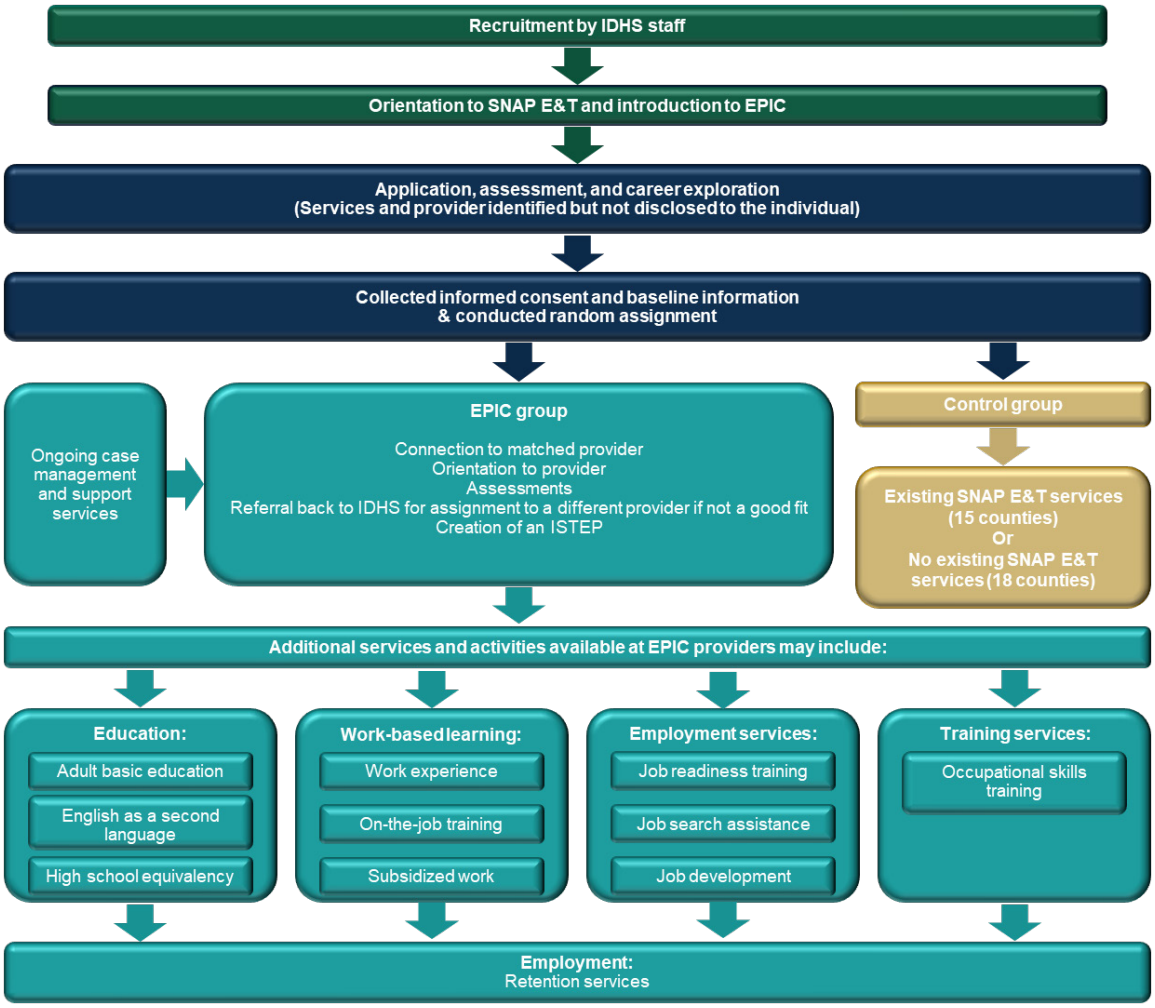
Figure B.4. Georgia's pilot client flow and pilot pathways



Notes: A complete written description of Georgia's client flow and pilot pathways can be found in Chapter IV, Section C of the Georgia Final Evaluation. The grantee had planned to offer work-based learning, but the activity was not offered systematically across SNAP Works 2.0 locations. Some regions offered work-based learning placements through WIOA funding to a small number of individuals.

DCF = Division of Family and Children Services

Figure B.5. Illinois' pilot client flow and pilot pathways



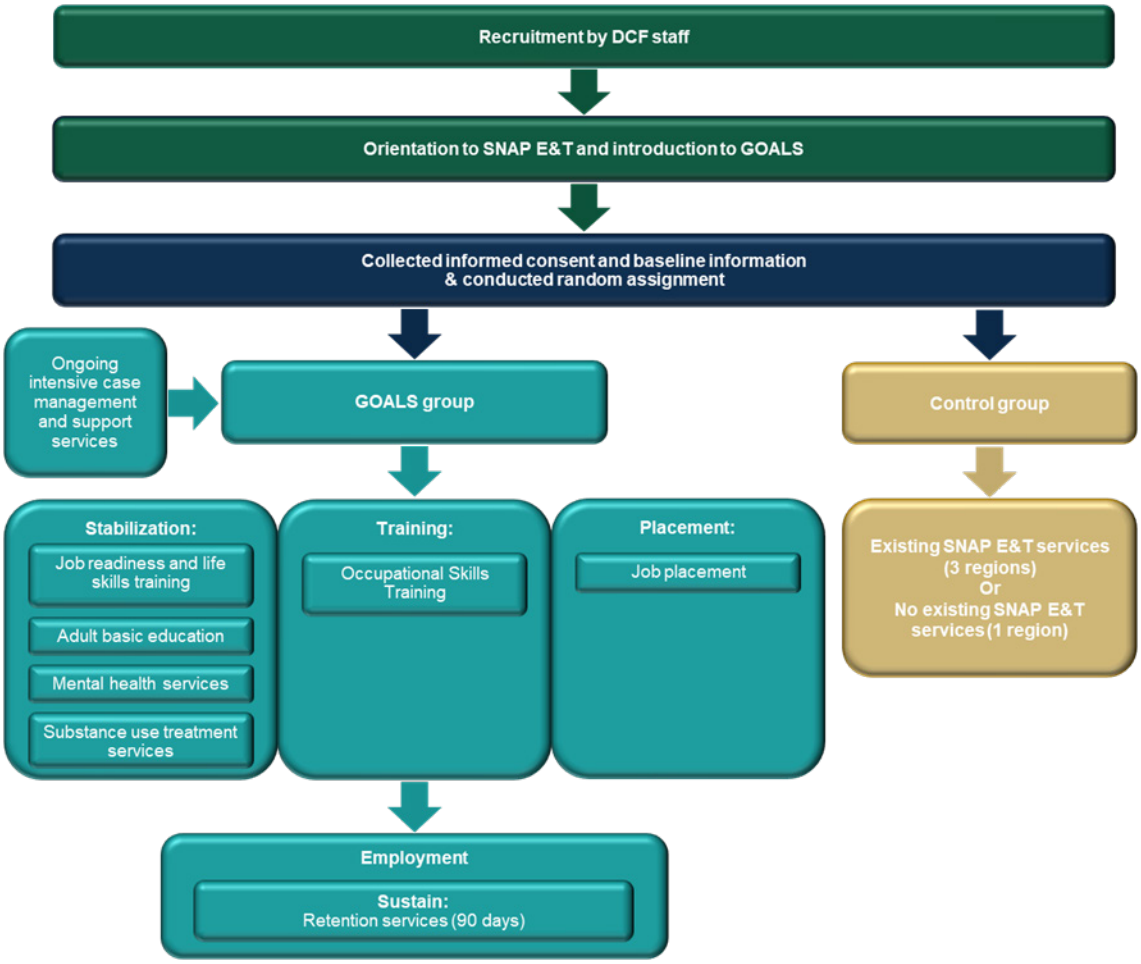
Note: A complete written description of Illinois' client flow and pilot pathways can be found in Chapter IV, Section C of the Illinois Final Evaluation

IDHS = Illinois Department of Human Services

EPIC = Employment Opportunities, Personalized Services, Individualized Training, and Career Planning

ISTEP = Individualized Services Training and Employment Plan

Figure B.6. Kansas' pilot client flow and pilot pathways

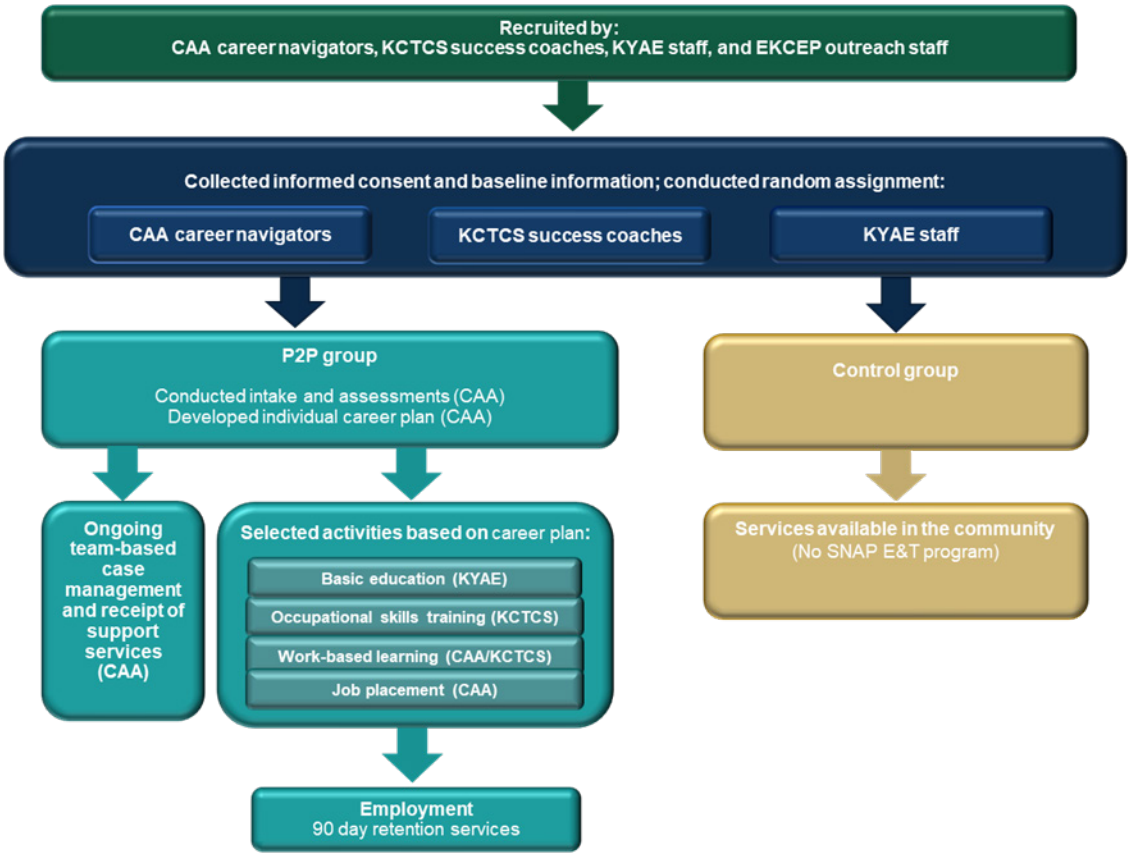


Note: A complete written description of Kansas' client flow and pilot pathways can be found in Chapter IV, Section C of the Kansas Final Evaluation

DCF = Kansas Department for Children and Families

GOALS = Generating Opportunities to Attain Lifelong Success

Figure B.7. Kentucky's pilot client flow and pilot pathways



Note: A complete written description of Kentucky's client flow and pilot pathways can be found in Chapter IV, Section C of the Kentucky Final Evaluation

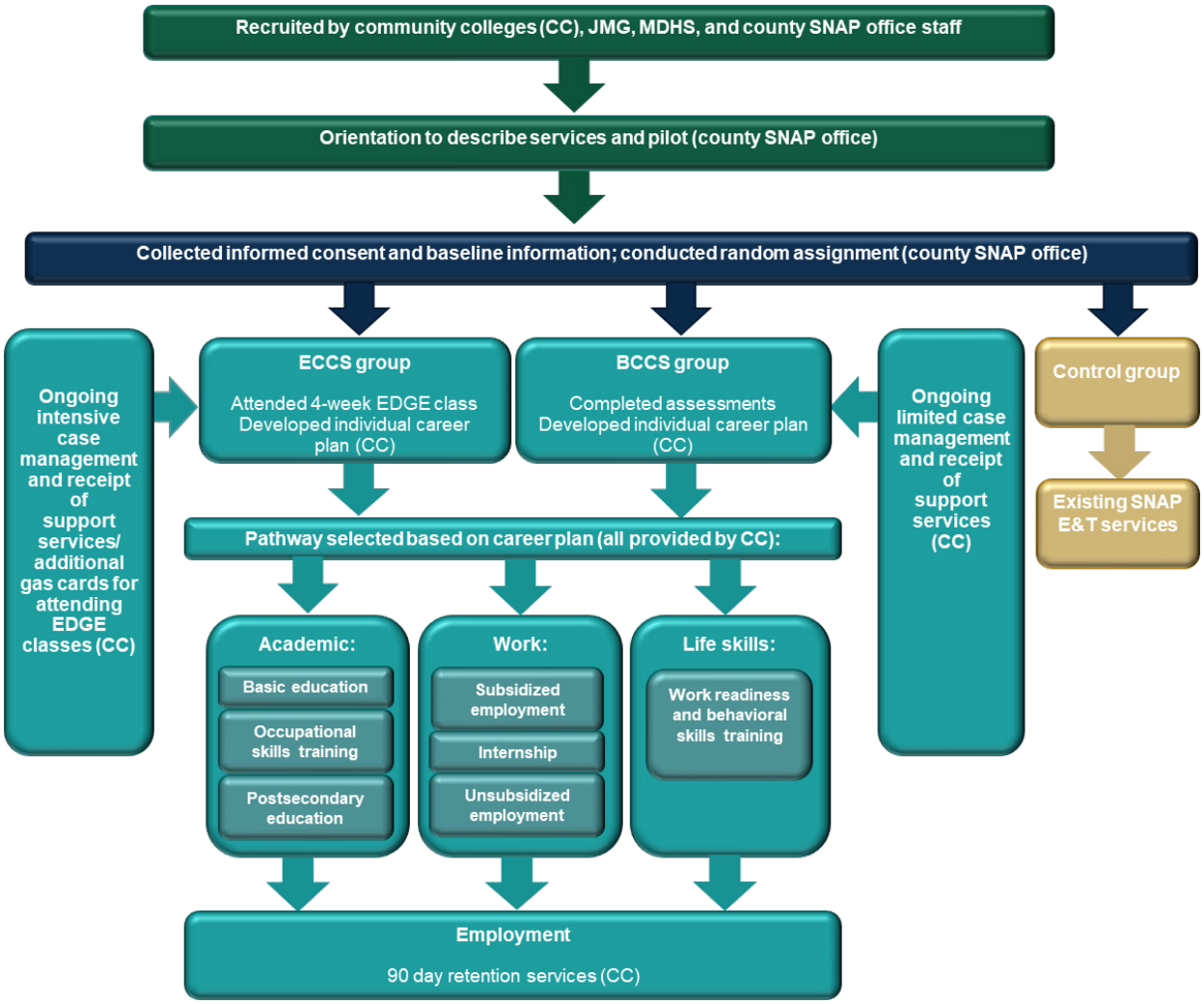
CAA = Community Action Agency

KCTCS = Kentucky Community and Technical College System

KYAE = Kentucky Adult Education

EKCEP = Eastern Kentucky Concentrated Employment Program

Figure B.8. Mississippi's pilot client flow and pilot pathways



Note: A complete written description of Mississippi's client flow and pilot pathways can be found in Chapter IV, Section C of the Mississippi Final Evaluation

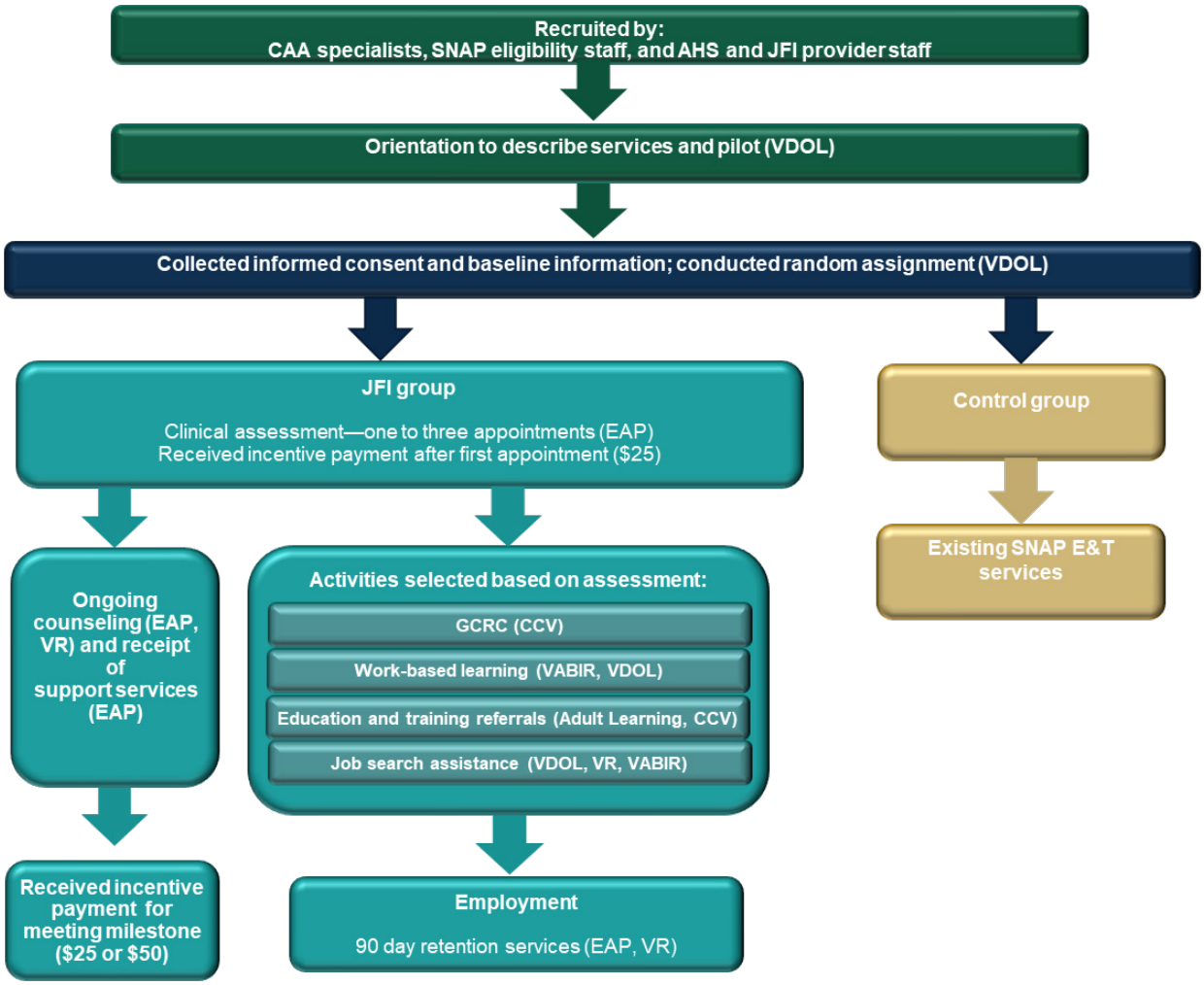
JMG = Jobs for Mississippi Graduates

MDHS = Mississippi Department of Human Services

ECCS = Enhanced Community College Services

BCCS = Basic Community College Services

Figure B.9. Vermont's pilot client flow and pilot pathways



Note: A complete written description of Vermont's client flow and pilot pathways can be found in Chapter IV, Section C of the Vermont Final Evaluation

JFI = Jobs for Independence

CAA = Community Action Agencies of Vermont

VDOL = Vermont Department of Labor

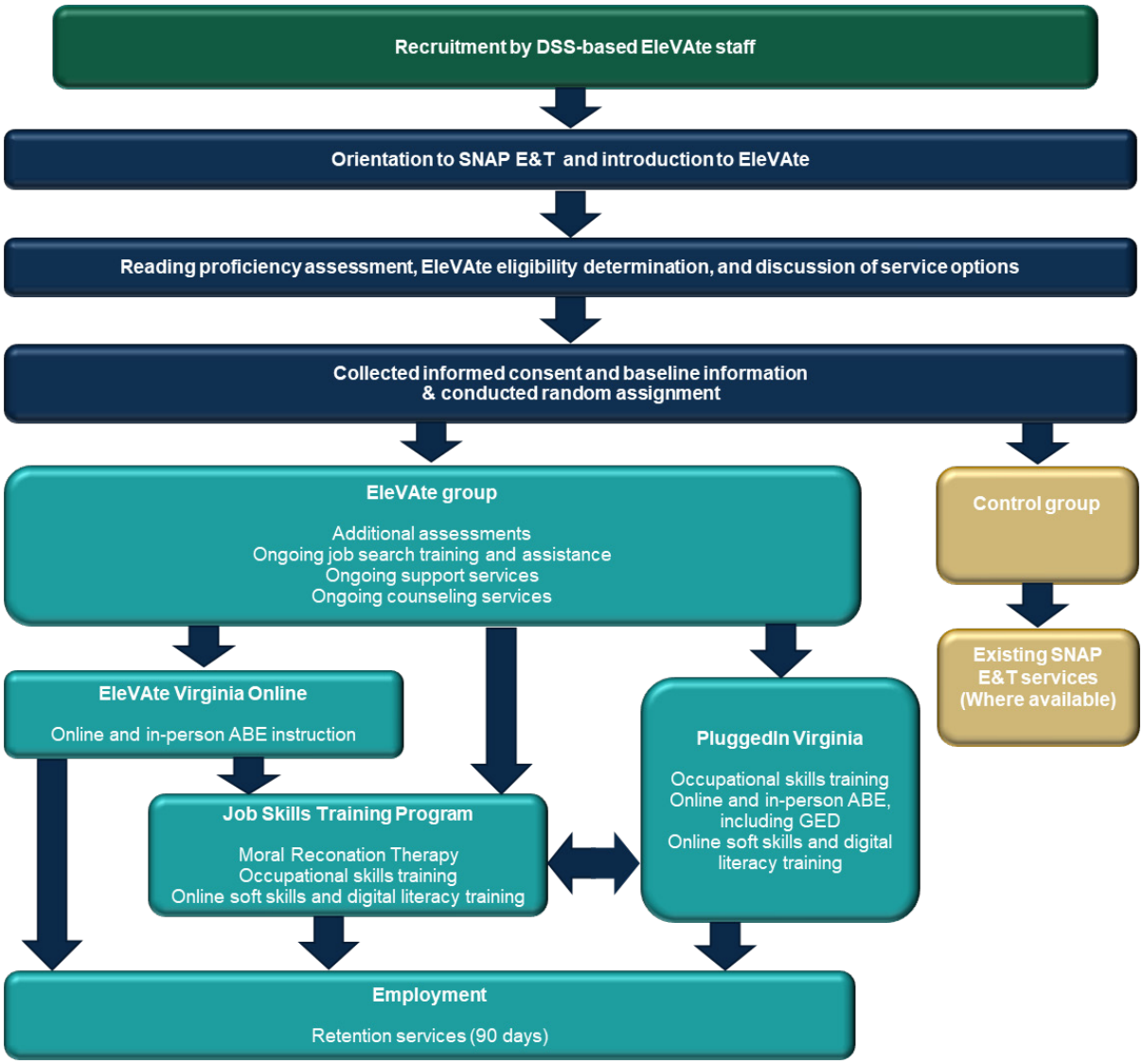
EAP = Employee Assistance Program

GCRC = Governor's Career Readiness Certificate

CCV = Community Colleges of Vermont

VR = Vermont Division of Vocational Rehabilitation

Figure B.10. Virginia's pilot client flow and pilot pathways



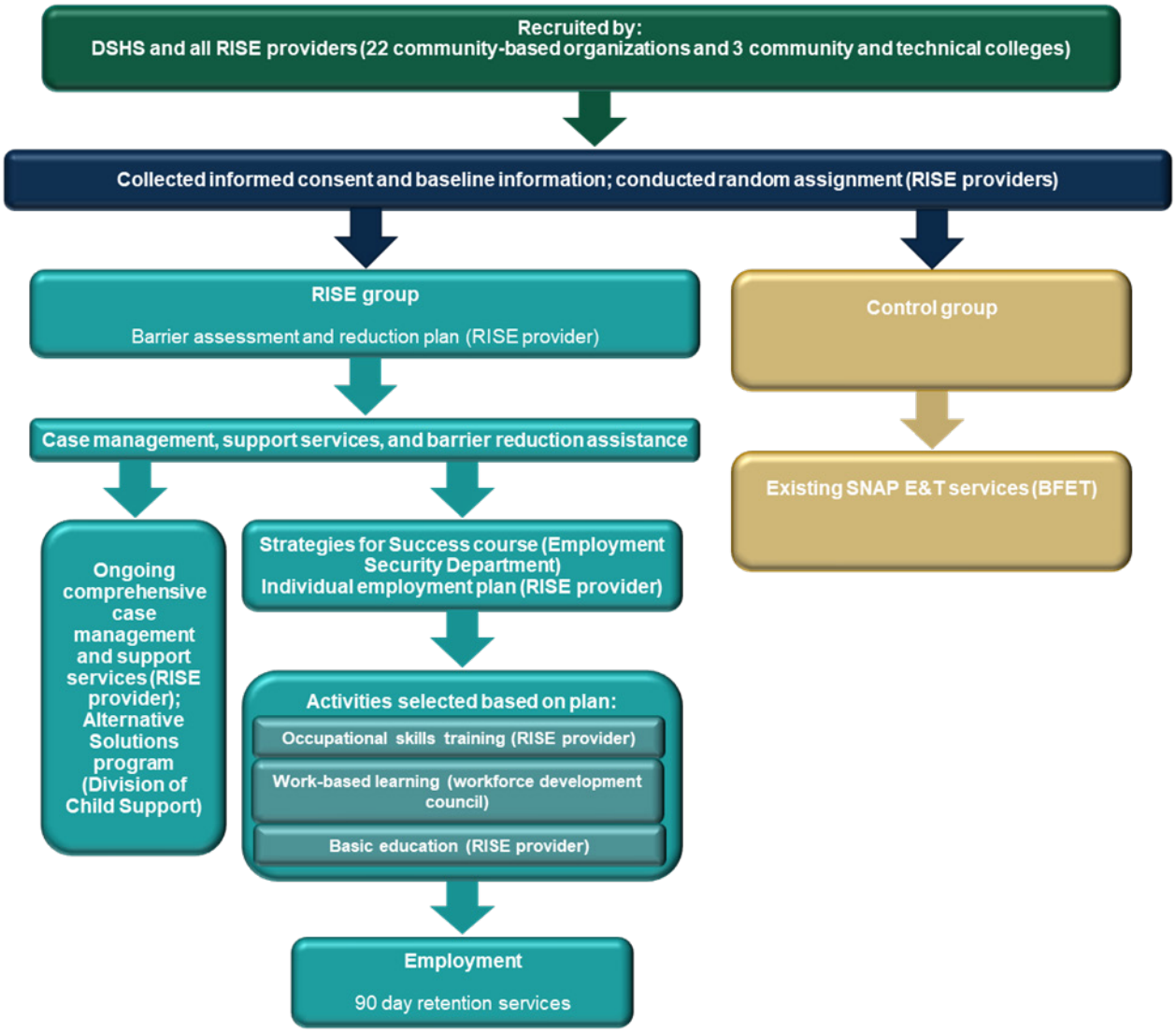
Note: A complete written description of Virginia's client flow and pilot pathways can be found in Chapter IV, Section C of the Virginia Final Evaluation

DSS = Virginia Department of Social Services

ABE = Adult basic education

GED = General Education Diploma

Figure B.11. Washington's pilot client flow and pilot pathways



Note: A complete written description of Washington's client flow and pilot pathways can be found in Chapter IV, Section C of the Washington Final Evaluation

RISE = Resources to Initiate Successful Employment

DSHS = Washington Department of Social and Health Services

BFET = Basic Food Employment and Training

Appendix C. Differences in participation in activities and service receipt for the treatment and control groups

Appendix Table C.1. Participation rates for any activity and core components of activities

	Any activity[a]			Job search assistance or job search training activities			Education or occupational skills training		
Pilot	Treatment group participated in activity	Control group participated in activity	Treatment–control difference	Treatment group participated in activity	Control group participated in activity	Treatment–control difference	Treatment group participated in activity	Control group participated in activity	Treatment–control difference
CA (NS)	84.9	47.9	37.1*** (2.7)	74.0	27.2	46.7*** (2.9)	67.5	36.3	31.2*** (3.0)
CA (ES)	84.9	75.2	9.9*** (3.6)	74.0	65.6	8.6** (3.8)	67.5	53.7	13.9*** (4.1)
DE	63.0	53.0	10.1*** (3.1)	55.3	39.6	15.7*** (3.1)	37.9	30.8	7.1** (2.9)
GA	73.0	51.8	21.2*** (2.6)	63.3	39.2	24.2*** (2.7)	42.8	31.4	11.4*** (2.6)
IL	75.1	56.6	18.5*** (2.6)	64.0	46.3	17.7*** (2.7)	57.3	35.5	21.8*** (2.7)
KS	65.2	52.0	13.2*** (3.2)	49.2	35.9	13.2*** (3.1)	43.6	34.9	8.7*** (3.2)
KY	70.1	49.7	20.3*** (3.8)	37.2	24.1	13.0*** (3.5)	61.3	38.1	23.2*** (3.8)
MS (ECCS)	75.7	54.4	21.3*** (4.5)	60.2	36.4	23.8*** (4.7)	64.5	34.0	30.5*** (4.7)
MS (BCCS)	64.4	54.4	10.3** (4.7)	35.0	36.4	-1.1 (4.8)	57.1	34.0	23.6*** (4.6)
VA	75.8	56.9	18.8*** (2.6)	55.0	37.5	17.6*** (2.7)	68.6	45.7	22.9*** (2.7)
VT	67.0	56.1	10.9*** (3.9)	56.4	47.4	9.0** (4.0)	44.1	28.8	15.3*** (3.6)
WA	72.17	64.3	7.84** (3.3)	62.0	50.2	11.8*** (3.5)	58.9	48.4	10.5*** (3.5)

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

[a]Activities include job search assistance or job search training, or education or occupational skills training.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services.

Appendix Table C.2. Rates of participation in job search training or assistance activities or in education or training programs, by year after random assignment

	Year 1 after random assignment			Years 2 and 3 after random assignment		
Pilot	Treatment group participated in activity	Control group participated in activity	Treatment–control difference	Treatment group participated in activity	Control group participated in activity	Treatment–control difference
CA (NS)	79.5	28.3	51.2*** (2.7)	46.2	31.9	14.3*** (3.0)
CA (ES)	79.6	70.3	9.3** (3.8)	46.4	38.8	7.6* (4.0)
DE	52.8	38.7	14.1*** (3.2)	31.8	30.4	1.4 (2.9)
GA	62.0	36.5	25.6*** (2.7)	39.5	29.3	10.2*** (2.6)
IL	65.9	42.7	23.2*** (2.7)	39.4	32.7	6.6** (2.6)
KS	52.0	39.9	12.1*** (3.2)	28.5	28.5	0.1 (2.9)
KY	60.3	37.6	22.7*** (3.9)	38.5	28.3	10.1*** (3.7)
MS (ECCS)	66.1	37.4	28.6*** (4.7)	32.5	31.9	0.6 (4.6)
MS (BCCS)	58.4	37.3	21.0*** (4.8)	27.8	31.6	-3.7 (4.5)
VA	68.5	44.7	23.8*** (2.7)	34.7	33.1	1.6 (2.7)
VT	56.2	43.7	12.5*** (4.0)	37.2	32.7	4.5 (3.7)
WA	64.0	54.9	9.1*** (3.4)	40.3	37.9	2.4 (3.4)

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table C.3. Rates of participation in specific types of activities

Pilot	Treatment group participated in activity	Control group participated in activity	Treatment–control difference	Treatment group participated in activity	Control group participated in activity	Treatment–control difference
	General job skills training			Occupational skills training		
CA (NS)	42.3	15.6	26.7*** (2.6)	41.8	23.3	18.5*** (2.9)
CA (ES)	42.2	29.6	12.6*** (3.8)	41.8	36.2	5.6 (4.0)
DE	24.7	13.7	11.0*** (2.4)	23.5	18.2	5.3** (2.4)
GA	22.1	15.8	6.3*** (2.1)	25.8	17.8	8.0*** (2.2)
IL	37.3	22.2	15.1*** (2.5)	36.1	20.5	15.6*** (2.4)
KS	23.7	17.5	6.2** (2.6)	27.5	17.7	9.8*** (2.6)
KY	33.3	16.4	16.9*** (3.2)	35.9	25.2	10.7*** (3.5)
MS (ECCS)	41.8	17.8	24.1*** (4.2)	43.9	17.6	26.2*** (4.3)
MS (BCCS)	33.5	17.1	16.4*** (4.2)	34.9	17.4	17.5*** (4.1)
VA	43.6	21.8	21.8*** (2.6)	49.6	31.0	18.6*** (2.7)
VT	28.7	15.7	13.1*** (3.0)	29.6	15.6	14.0*** (3.1)
WA	43.7	32.1	11.6*** (3.4)	35.1	32.1	3.0 (3.2)
	Education			Work-based learning		
CA (NS)	36.1	17.0	19.1*** (2.6)	0.3	0.3	0.0 (0.3)
CA (ES)	36.1	23.4	12.7*** (3.5)	0.3	0.7	-0.4 (0.7)
DE	15.1	15.8	-0.8 (2.2)	0.9	0.0	0.9*** (0.3)
GA	18.6	13.1	5.5*** (2.0)	0.2	0.0	0.2* (0.1)
IL	21.5	13.4	8.2*** (2.1)	0.8	0.3	0.5 (0.4)
KS	20.2	17.7	2.5 (2.5)	0.1	0.0	0.1 (0.1)
KY	34.6	21.5	13.1*** (3.3)	0.5	0.0	0.5** (0.2)
MS (ECCS)	35.6	15.4	20.2*** (4.0)	1.0	0.0	1.0** (0.5)
MS (BCCS)	28.6	15.7	12.9*** (3.9)	0.1	0.0	0.1 (0.2)
VA	28.3	20.8	7.5*** (2.4)	0.6	0.1	0.5* (0.3)
VT	24.6	10.9	13.7*** (2.7)	0.2	0.2	0.0 (0.2)
WA	24.6	22.6	2.0 (2.9)	0.3	0.4	-0.1 (0.2)

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table C.4. Rates of completion of education and training programs and activities and receipt of credentials

Pilot	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference
	Percentage that completed education and training programs and activities			Among individuals who started education or training programs or activities, percentage that completed		
CA (NS)	43.1	20.2	22.9*** (2.8)	64.2	56.0	8.2** (4.1)
CA (ES)	43.1	36.4	6.6* (3.9)	64.2	66.9	-2.8 (4.9)
DE	26.2	18.2	8.0*** (2.5)	64.7	57.4	7.4 (4.8)
GA	26.8	20.0	6.8*** (2.3)	63.6	63.5	0.1 (4.6)
IL	40.4	23.2	17.3*** (2.5)	70.3	66.3	4.0 (3.8)
KS	31.8	22.6	9.3*** (2.8)	71.8	65.7	6.1 (4.7)
KY	42.6	23.8	18.8*** (3.6)	68.6	62.4	6.2 (5.5)
MS (ECCS)	47.0	21.2	25.8*** (4.5)	71.9	62.5	9.4 (6.1)
MS (BCCS)	32.7	21.2	12.2*** (4.1)	54.4	62.5	-5.7 (6.4)
VA	49.0	28.6	20.5*** (2.6)	70.7	61.9	8.8** (3.6)
VT	32.4	16.0	16.4*** (3.2)	68.5	56.7	11.8** (5.5)
WA	43.4	31.2	12.2*** (3.2)	72.8	64.7	8.1** (4.1)
	Percentage that received an occupational certificate or license			Among individuals who started education or training programs or activities, percentage that received an occupational certificate or license		
CA (NS)	19.6	10.4	9.2*** (2.1)	29.0	28.9	0.0 (4.2)
CA (ES)	19.6	21.3	-1.8 (3.2)	28.8	38.7	-9.9** (4.6)
DE	13.8	9.0	4.8*** (1.9)	34.0	29.1	4.9 (4.9)
GA	14.2	9.3	4.9*** (1.7)	34.0	29.4	4.6 (4.2)
IL	25.6	11.9	13.7*** (2.0)	43.6	34.1	9.5** (3.8)
KS	18.8	12.7	6.1*** (2.2)	41.9	37.5	4.4 (4.7)
KY	22.9	12.4	10.4*** (2.9)	36.4	31.6	4.8 (5.3)
MS (ECCS)	30.3	9.5	20.7*** (3.5)	43.6	28.3	15.3*** (5.9)
MS (BCCS)	21.9	9.5	12.8*** (3.2)	33.1	26.4	6.6 (6.1)
VA	38.2	18.5	19.7*** (2.4)	54.7	39.9	14.9*** (3.8)
VT	16.2	9.1	7.1*** (2.5)	35.3	32.4	2.9 (6.0)
WA	21.5	18.2	3.3 (2.7)	37.1	38.6	-1.6 (4.5)

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table C.5. Rates of completion of education and training programs and activities and receipt of credentials, by year after random assignment

Pilot	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference
	Percentage that completed education and training programs and activities in Year 1 after random assignment			Percentage that completed education and training programs and activities in Year 2 after random assignment			Percentage that completed education and training programs and activities in Year 3 after random assignment		
CA (NS)	17.4	5.3	12.0*** (1.8)	20.1	7.4	12.7*** (2.0)	13.6	7.0	6.6*** (1.8)
CA (ES)	17.4	15.8	1.4 (2.7)	20.1	17.3	3.0 (3.2)	13.6	8.2	5.1** (2.5)
DE	14.2	6.1	8.1*** (1.7)	8.9	6.9	2.0 (1.6)	6.4	6.1	0.3 (1.4)
GA	13.7	7.9	5.8*** (1.7)	11.6	6.9	4.6*** (1.5)	6.3	7.4	-1.0 (1.4)
IL	27.8	12.5	15.3*** (2.1)	11.4	10.0	1.4 (1.6)	8.8	5.6	3.2** (1.4)
KS	18.9	12.4	6.5*** (2.3)	9.4	8.8	0.6 (1.8)	7.5	5.3	2.2 (1.5)
KY	20.8	9.7	11.2*** (2.6)	15.4	11.2	4.2 (2.6)	16.8	6.4	10.4*** (2.2)
MS (ECCS)	30.0	10.2	19.8*** (3.8)	14.0	5.3	8.7*** (2.6)	7.8	7.5	0.3 (2.6)
MS (BCCS)	18.5	10.2	8.6*** (3.3)	13.8	5.3	8.5*** (2.5)	6.2	7.5	-1.0 (2.4)
VA	35.2	16.8	18.3*** (2.3)	14.1	8.5	5.6*** (1.7)	7.6	8.1	-0.4 (1.5)
VT	17.2	9.7	7.5*** (2.6)	11.3	5.0	6.4*** (1.9)	9.8	5.7	4.1** (2.0)
WA	27.7	16.4	11.3*** (2.7)	13.9	10.4	3.5* (2.1)	9.9	9.7	0.2 (1.9)
	Percentage that received an occupational certificate or license in Year 1 after random assignment			Percentage that received an occupational certificate or license in Year 2 after random assignment			Percentage that received an occupational certificate or license in Year 3 after random assignment		
CA (NS)	8.5	2.1	6.4*** (1.3)	6.7	3.6	3.1** (1.4)	5.5	4.2	1.3 (1.2)
CA (ES)	8.5	8.9	-0.5 (2.1)	6.7	10.5	-3.7 (2.5)	5.5	3.1	2.3 (1.4)
DE	7.5	3.5	3.9*** (1.3)	3.2	3.4	-0.2 (1.0)	3.6	3.1	0.5 (1.0)
GA	6.8	3.1	3.8*** (1.1)	6.5	4.2	2.2* (1.3)	3.2	3.0	0.2 (0.9)
IL	18.0	5.7	12.3*** (1.6)	7.1	4.8	2.3* (1.2)	4.6	2.2	2.4*** (0.9)
KS	10.6	7.0	3.7** (1.7)	5.1	4.9	0.3 (1.4)	4.4	2.5	1.9* (1.0)
KY	11.6	5.5	6.1*** (2.1)	5.6	5.0	0.7 (1.7)	8.3	2.5	5.9*** (1.6)
MS (ECCS)	18.7	5.4	13.4*** (3.0)	9.0	1.9	7.1*** (1.9)	5.5	3.2	2.3 (1.9)
MS (BCCS)	13.3	5.4	8.2*** (2.7)	7.5	1.9	5.7*** (1.7)	3.5	3.2	0.4 (1.4)
VA	27.3	11.0	16.4*** (2.1)	10.3	4.1	6.2*** (1.4)	4.7	5.4	-0.7 (1.2)

Appendix Table C.5. Rates of completion of education and training programs and activities and receipt of credentials, by year after random assignment *(continued)*

Pilot	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference
VT	8.2	4.3	3.9** (1.9)	6.5	3.2	3.3** (1.4)	3.4	3.1	0.3 (1.3)
WA	13.0	9.1	3.9* (2.1)	5.5	5.4	0.1 (1.5)	3.4	5.0	-1.7 (1.1)

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table C.6. Receipt of case management and support services

	Treatment group	Control group	Treatment-control difference
Percentage that received career counseling or one-on-one assistance from employment professional or case manager			
CA (NS)	68.4	26.2	42.2*** (2.8)
CA (ES)	68.4	62.4	6.2 (3.9)
DE	60.1	42.0	18.1*** (3.1)
GA	59.6	37.2	22.4*** (2.7)
IL	57.2	44.5	12.7*** (2.7)
KS	66.2	52.8	13.4*** (3.1)
KY	48.8	30.0	18.8*** (3.6)
MS (ECCS)	45.3	38.3	7.0 (4.7)
MS (BCCS)	44.2	38.0	6.2 (4.7)
VA	44.4	38.9	5.5** (2.7)
VT	78.3	68.2	10.1*** (3.3)
WA	66.1	56.4	9.6*** (3.5)
Percentage that received any support service			
CA (NS)	65.0	46.3	18.7*** (2.9)
CA (ES)	65.0	57.7	7.5** (3.7)
DE	67.5	58.0	9.5*** (3.0)
GA	42.9	29.8	13.1*** (2.6)
IL	58.8	50.0	8.9*** (2.7)
KS	76.2	68.2	8.0*** (2.9)
KY	69.9	47.2	22.7*** (3.9)
MS (ECCS)	56.7	42.5	14.2*** (4.7)
MS (BCCS)	51.6	42.5	9.4** (4.6)
VA	72.0	62.6	9.4*** (2.6)
VT	86.8	80.8	6.0** (2.9)
WA	82.6	72.8	9.8*** (2.9)

Source: SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix D.
Impacts on earnings, SNAP participation, and other outcomes

Appendix Table D.1. Earnings in Years 2 and 3

Pilot	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference
	Earnings based on UI wage records			Earnings based on survey data		
CA (NS)	20,754	20,031	724 (741)	28,564	24,626	3,938** (1,678)
CA (ES)	20,754	20,366	388 (1,016)	28,564	26,915	1,666 (2,040)
DE	16,105	16,571	-466 (598)	30,217	32,087	-1,870 (1,820)
GA	19,264	18,228	1,035 (667)	30,126	29,435	692 (1,541)
IL	17,806	16,895	911 (584)	28,267	27,143	1,123 (1,645)
KS	18,350	17,446	904 (652)	31,319	29,635	1,684 (1,722)
KY	15,134	14,744	391 (744)	21,194	20,417	778 (1,797)
MS (ECCS)	14,161	11,833	2,328** (922)	26,982	24,862	2,120 (2,428)
MS (BCCS)	13,440	11,833	1,608* (893)	22,522	24,862	-2,021 (2,447)
VA	18,309	19,342	-1,033 (647)	27,856	25,094	2,761* (1,587)
VT	15,765	15,562	203 (802)	28,769	26,501	2,357 (2,487)
WA	17,024	16,922	102 (649)	29,828	29,873	-45 (2,225)

Source: SNAP employment and training evaluation UI wage records, weighted data. SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table D.2. Employment and SNAP participation rates in Years 2 and 3

	Employment rate in Years 2 and 3 based on UI wage records			Employment rate in Years 2 and 3 based on survey data			SNAP participation in Years 2 and 3		
Pilot	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference
CA (NS)	72.9	73.0	-0.1 (1.4)	78.8	72.4	6.4** (2.5)	83.1	83.7	-0.5 (1.3)
CA (ES)	72.9	72.2	0.7 (2.0)	78.8	80.0	-1.3 (3.4)	83.1	83.7	-0.6 (1.7)
DE	68.9	69.7	-0.8 (1.3)	83.8	83.0	0.8 (2.3)	67.0	65.3	1.6 (1.3)
GA	74.5	72.5	2.0 (1.3)	83.3	84.1	-0.8 (2.0)	56.4	56.7	-0.3 (1.4)
IL	71.2	70.2	1.0 (1.2)	82.9	77.0	5.9*** (2.2)	72.2	74.6	-2.4** (1.2)
KS	75.6	71.1	4.5*** (1.4)	86.1	82.1	4.1* (2.2)	69.4	67.5	1.9 (1.4)
KY	70.8	66.5	4.3** (1.8)	76.6	73.1	3.5 (3.1)	85.3	84.3	1.0 (1.4)
MS (ECCS)	68.8	67.1	1.8 (2.4)	83.7	83.0	0.7 (3.2)	61.7	60.0	1.7 (2.4)
MS (BCCS)	70.2	67.1	3.1 (2.4)	79.3	83.0	-3.4 (3.6)	64.1	60.0	4.1* (2.5)
VA	74.4	75.4	-1.1 (1.4)	80.4	79.5	0.9 (2.0)	78.9	76.5	2.4* (1.3)
VT	64.2	64.7	-0.5 (1.8)	72.7	66.8	5.9* (3.3)	74.8	75.2	-0.4 (1.5)
WA	63.7	62.7	1.0 (1.3)	73.0	71.3	1.7 (3.0)	82.4	80.9	1.5 (1.1)

Source: SNAP employment and training UI wage records, 12-and 36-month surveys; SNAP administrative data, weighted data

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services.

Appendix Table D.3. Earnings, by year and pilot

Pilot	Earnings in Year 1			Earnings in Year 2			Earnings in Year 3		
	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference
Earnings based on UI wage records									
CA (NS)	7,056	6,564	492* (272)	9,777	9,320	457 (371)	10,978	10,711	267 (425)
CA (ES)	7,056	6,962	94 (367)	9,777	9,225	551 (503)	10,978	11,140	-163 (595)
DE	6,568	6,937	-369* (219)	7,799	8,105	-306 (276)	8,279	8,395	-116 (337)
GA	7,311	7,565	-255 (258)	9,240	8,934	306 (321)	9,889	9,335	554 (372)
IL	5,673	5,865	-192 (214)	8,432	8,239	194 (296)	9,369	8,662	707** (329)
KS	7,739	7,456	283 (248)	9,133	8,615	519* (312)	9,204	8,975	228 (366)
KY	5,029	5,256	-226 (263)	7,068	7,075	-6 (364)	8,013	7,703	310 (428)
MS (ECCS)	5,001	4,498	503 (331)	6,858	5,680	1,178*** (447)	7,350	6,165	1,185** (527)
MS (BCCS)	4,814	4,498	316 (319)	6,520	5,680	840** (424)	6,932	6,165	767 (510)
VA	6,974	7,573	-599*** (226)	9,176	9,562	-386 (307)	9,274	9,835	-561 (363)
VT	6,581	6,759	-178 (300)	8,013	7,741	272 (379)	7,880	7,828	52 (448)
WA	6,879	6,918	-38 (262)	8,468	8,406	63 (335)	8,556	8,516	39 (363)
Earnings based on survey data									
CA (NS)	7,828	6,357	1,471*** (560)	13,921	11,983	1,937** (911)	14,644	12,643	2,001** (906)
CA (ES)	7,828	7,313	532 (722)	13,921	12,760	1,179 (1,104)	14,644	14,155	487 (1,125)
DE	9,220	10,857	-1,637** (799)	14,263	16,014	-1,750* (924)	15,954	16,073	-119 (1,042)
GA	9,396	8,787	610 (672)	15,130	14,335	796 (842)	14,996	15,100	-104 (840)
IL	6,669	6,857	-188 (514)	14,286	13,481	805 (904)	13,980	13,662	318 (883)
KS	10,297	9,513	784 (697)	15,772	14,638	1,134 (972)	15,547	14,997	549 (928)
KY	5,773	5,698	75 (624)	10,365	9,391	974 (880)	10,829	11,026	-197 (1,046)
MS (ECCS)	7,080	7,316	-235 (902)	12,630	11,993	638 (1,363)	14,352	12,869	1,483 (1,367)
MS (BCCS)	6,628	7,316	-622 (924)	11,320	11,993	-508 (1,392)	11,202	12,869	-1,513 (1,288)
VA	7,731	8,092	-361 (493)	13,713	12,522	1,191 (996)	14,143	12,573	1,570** (777)
VT	8,548	8,871	-322 (841)	15,207	13,256	1,950 (1,310)	13,562	13,244	318 (1,324)
WA	9,192	10,172	-981 (821)	14,735	14,852	-118 (1,156)	15,093	15,021	72 (1,214)

Appendix Table D.3. Earnings, by year and pilot *(continued)*

Source: SNAP employment and training evaluation UI wage records, weighted data. SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table D.4. SNAP participation, by year and pilot

Pilot	SNAP participation in Year 1			SNAP participation in Year 2			SNAP participation in Year 3		
	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference
CA (NS)	98.7	98.6	0.1 (0.4)	80.6	80.7	-0.1 (1.4)	66.3	69.3	-3.0* (1.6)
CA (ES)	98.7	97.8	1.0 (0.6)	80.6	81.2	-0.6 (1.8)	66.3	69.0	-2.7 (2.2)
DE	99.2	98.4	0.8*** (0.3)	60.4	57.6	2.8** (1.3)	49.4	49.5	-0.2 (1.3)
GA	97.8	96.9	0.9* (0.5)	48.5	47.9	0.6 (1.4)	41.1	42.6	-1.6 (1.4)
IL	98.2	98.3	-0.1 (0.4)	64.1	67.4	-3.3** (1.3)	58.4	61.5	-3.1** (1.3)
KS	99.6	98.9	0.7*** (0.3)	63.1	61.2	1.9 (1.4)	53.7	52.6	1.1 (1.5)
KY	98.5	97.7	0.9* (0.5)	81.8	79.6	2.1 (1.5)	70.2	70.3	-0.1 (1.7)
MS (ECCS)	99.0	98.1	0.9 (0.6)	54.5	50.1	4.5* (2.5)	42.9	47.1	-4.2* (2.5)
MS (BCCS)	99.1	98.1	1.0* (0.6)	56.2	50.1	6.1** (2.5)	45.5	47.1	-1.5 (2.5)
VA	97.8	97.3	0.5 (0.5)	74.9	71.2	3.7*** (1.3)	62.2	62.8	-0.6 (1.5)
VT	99.0	98.8	0.2 (0.4)	69.4	69.9	-0.5 (1.6)	60.5	63.2	-2.6 (1.8)
WA	98.8	98.6	0.2 (0.3)	77.8	76.5	1.4 (1.2)	68.9	68.3	0.6 (1.3)

Source: SNAP administrative data, weighted data

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table D.5. Employment rate, by year and pilot

Pilot	Employment rate in Year 1			Employment rate in Year 2			Employment rate in Year 3		
	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference	Treatment group	Control group	Treatment–control difference
Employment rate based on UI wage records									
CA (NS)	65.4	64.1	1.3 (1.5)	66.8	65.7	1.1 (1.5)	63.6	63.6	0.0 (1.6)
CA (ES)	65.4	65.6	-0.2 (2.0)	66.8	63.5	3.3 (2.1)	63.6	63.9	-0.3 (2.2)
DE	69.6	69.3	0.3 (1.2)	62.1	62.1	0.0 (1.2)	57.4	58.0	-0.6 (1.4)
GA	71.1	69.7	1.4 (1.2)	66.3	64.7	1.5 (1.3)	64.2	62.2	2.0 (1.5)
IL	65.0	63.9	1.1 (1.2)	63.5	63.1	0.4 (1.3)	60.7	60.0	0.7 (1.3)
KS	77.7	75.3	2.4* (1.2)	69.7	65.4	4.3*** (1.4)	63.6	61.5	2.1 (1.6)
KY	63.8	59.0	4.8*** (1.8)	62.3	57.5	4.8*** (1.8)	59.6	57.4	2.2 (1.9)
MS (ECCS)	61.7	61.8	-0.1 (2.3)	60.4	58.1	2.3 (2.4)	58.9	55.1	3.8 (2.6)
MS (BCCS)	64.5	61.8	2.8 (2.3)	63.0	58.1	4.9** (2.4)	57.4	55.1	2.4 (2.6)
VA	70.9	73.0	-2.2* (1.3)	68.2	69.4	-1.2 (1.3)	65.3	67.5	-2.2 (1.5)
VT	64.5	64.9	-0.3 (1.6)	57.6	58.4	-0.8 (1.7)	52.3	52.9	-0.7 (2.0)
WA	64.2	63.4	0.8 (1.3)	57.5	56.3	1.2 (1.4)	52.5	51.0	1.5 (1.4)
Employment rate based on survey data									
CA (NS)	59.0	49.4	9.6*** (2.8)	71.8	65.3	6.5** (2.7)	70.7	64.1	6.6** (2.9)
CA (ES)	59.0	55.8	3.2 (3.8)	71.8	71.3	0.5 (3.7)	70.7	71.9	-1.4 (3.7)
DE	62.2	65.1	-2.9 (2.9)	76.6	77.0	-0.4 (2.6)	72.5	73.6	-1.1 (2.7)
GA	61.1	59.7	1.3 (2.6)	76.4	76.4	-0.1 (2.3)	74.9	73.9	1.1 (2.4)
IL	55.6	53.5	2.2 (2.7)	75.3	68.8	6.5*** (2.5)	71.4	69.3	2.1 (2.5)
KS	70.3	69.1	1.2 (3.0)	79.2	74.7	4.5* (2.6)	77.4	74.6	2.9 (2.6)
KY	54.9	49.8	5.1 (3.6)	69.7	63.9	5.7* (3.4)	65.0	62.8	2.2 (3.6)
MS (ECCS)	59.6	59.7	-0.1 (4.4)	75.5	70.2	5.3 (4.0)	75.4	75.7	-0.2 (3.8)
MS (BCCS)	55.3	59.7	-4.1 (4.6)	69.9	70.2	0.1 (4.3)	68.5	75.7	-6.9* (4.0)
VA	59.2	64.6	-5.3** (2.5)	74.2	72.2	2.0 (2.3)	72.3	71.8	0.5 (2.4)
VT	59.8	59.7	0.1 (3.6)	64.7	61.2	3.4 (3.6)	65.8	58.3	7.6** (3.4)
WA	62.2	59.9	2.3 (3.1)	67.4	63.8	3.6 (3.2)	65.5	62.6	2.9 (3.2)

Appendix Table D.5. Employment rate, by year and pilot *(continued)*

Source: SNAP employment and training evaluation UI wage records, weighted data. SNAP employment and training evaluation 12- and 36-month surveys, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services

Appendix Table D.6. Food security status based on 36-month survey data

Pilot	Treatment group	Control group	Treatment-control difference	Treatment group	Control group	Treatment-control difference
	Living in a household that is food insecure			Living in a household with very low food security		
CA (NS)	42.5	49.6	-7.1** (3.1)	23.2	30.6	-7.5*** (2.8)
CA (ES)	42.5	37.4	5.2 (4.1)	23.2	22.0	1.3 (3.4)
DE	51.2	48.1	3.0 (3.1)	33.3	30.6	2.6 (2.9)
GA	52.9	52.7	0.2 (2.8)	34.8	34.2	0.6 (2.7)
IL	52.4	50.1	2.3 (2.8)	32.7	33.2	-0.6 (2.6)
KS	51.4	49.6	1.8 (3.3)	32.7	31.4	1.3 (3.1)
KY	44.8	42.6	2.1 (3.9)	31.2	30.6	0.6 (3.6)
MS (ECCS)	54.7	55.3	-0.6 (4.7)	37.0	40.5	-3.5 (4.5)
MS (BCCS)	48.7	55.3	-6.5 (4.7)	30.5	40.5	-10.1** (4.4)
VA	44.6	48.6	-4.0 (2.8)	28.2	26.9	1.3 (2.5)
VT	53.1	53.3	-0.2 (3.9)	38.0	38.1	-0.1 (3.8)
WA	47.2	52.5	-5.3 (3.4)	29.8	32.9	-3.1 (3.2)

Source: SNAP employment and training evaluation 36-month survey, weighted data.

Note: Standard errors in parentheses.

***/**/* Difference between the treatment group and control group is significantly different from zero at the 0.01/0.05/0.10 level, two-tailed test.

BCCS = Basic Community College Services. ECCS = Enhanced Community College Services. ES = Enhanced Services. NS = No Services.