Expanding Opportunities & Reducing Barriers to Work: Interim Summary Report

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

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James Mabli, Gretchen Rowe, Gayle Hamilton, Julie Hartnack, Peter Schochet

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Food Nutrition Service
1320 Braddock Place
Alexandria, VA 22314
Project Officer: Danielle Deemer
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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 (OPS)
Danielle Deemer (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 (Center on Budget and Policy Priorities)
Amy Ellen Duke-Benfield (National Skills Coalition)
David Greenberg (University of Maryland, Baltimore County)
Alma Salazar (Los Angeles Area Chamber of Commerce)
Jeffrey Smith (University of Wisconsin-Madison)
Whitney Smith (JP Morgan Chase Foundation)

Mathematica

Adam Bourgault
Jennifer Brown
Felita Buckner
Barbara Carlson
Mason DeCamillis
Amy Defnet
Dallas Dotter
Lisa Dragoset
Brittany English
Mary Kay Fox
Julie Hartnack
Kristen Joyce
Miranda Kharsa
Wamaitha Kiambuthi
Cathy Lu
Julia Lyskawa
James Mabli
Sheena McConnell
Kelley Monzella
Quinn Moore
Nora Paxton
Michael Ponza
Linda Rosenberg
Gretchen Rowe
Betsy Santos
Peter Schochet
Dan Thal
Andy Weiss
Dan Welsh

MDRC

Jonathan Bigelow
Stephen Freedman
Barbara Goldman
Gayle Hamilton
Brandon Hawkins
Richard Hendra
Gloriela Iguina-Colón
Anastasia Korolkova
Frieda Molina
David Navarro
Keith Olejniczak
Nikki Ortolani
Liza Paudel
Alexandra Pennington
Natasha Piatnitskaia
Stephanie Rubino
Kelsey Schaberg
Susan Scrivener
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

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EXECUTIVE SUMMARY

The Supplemental Nutrition Assistance Program (SNAP) is the primary source of nutrition assistance for many low-income individuals and families. The program provides monthly benefits to help SNAP participants obtain adequate access to food, but for some in the program, it also provides work supports to help them become economically self-sufficient. As part of SNAP, States administer SNAP Employment and Training (E&T) programs, which assist SNAP participants in obtaining employment by providing services, such as job search assistance, job skills training, education, or work experience and supports, such as assistance with transportation or child care costs.

Despite the importance of SNAP E&T, information about approaches that most effectively connect SNAP participants to gainful employment is limited. For this reason, as part of the Agricultural Act of 2014 (P.L. 113-79), Congress authorized and funded pilots to test innovative strategies to connect SNAP participants with jobs that would increase their incomes and reduce their need for public assistance benefits. The legislation that authorized the pilots also included funding for a rigorous, longitudinal evaluation to assess the impacts of the pilots.

In 2015, the U.S. Department of Agriculture's (USDA) Food and Nutrition Service (FNS) awarded grants to 10 States—California, Delaware, Georgia, Illinois, Kansas, Kentucky, Mississippi, Vermont, Virginia, and Washington—that represented diverse service areas and populations.[1] The States varied in whether they operated pilots statewide or in select areas within a State, and whether the pilots focused on urban communities, rural communities, or both. Most of the 10 pilots targeted work registrants[2] who were unemployed or underemployed, but other pilots focused on individuals with significant barriers to employment, such as being homeless or having a criminal history or substance use disorder. Pilots also varied in the services they offered, but services typically included a skills and/or clinical assessment that determined individuals' work readiness, skills, and barriers to employment; case-management services that developed and supported a detailed and individualized work and barrier-reduction plan for individuals; and support services, such as transportation assistance, housing assistance, and training and work supplies. Offered services also included a range of E&T activities, such as job readiness training, basic education, occupational skills training, and subsidized employment, although not every pilot offered all of these services. Pilot enrollment began between January

[1] SNAP in California is county administered and only Fresno County was conducting the pilot; however, FNS awarded the grant to the State SNAP agency. The State oversaw the pilot, but Fresno County primarily administered it. Although Fresno County led the pilot, to align with how we refer to other pilots, we will refer to the Fresno pilot as California.

[2] Work registrants are SNAP participants who have not met any Federal exemptions from SNAP work requirements and are therefore required to, among other things, 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.

and April 2016, depending on the pilot. Each pilot enrolled 3,000 to 7,000 individuals for a total of 44,359 individuals across all pilots.

This interim summary report summarizes the findings from the interim evaluation reports prepared for each of the 10 pilots. These evaluations measured service use and short-term effects on employment and SNAP receipt for individuals enrolled in the pilots between early 2016 and the end of 2017. The findings cover services received and outcomes measured for a 12-month period for each individual, starting from their pilot enrollment date. The full effects of the pilot services, however, may not have materialized during this short-term, 12-month follow-up period, especially for some individuals who were still receiving services in the twelfth month. In addition, some pilots continued to enroll and provide services to individuals in 2018 and 2019. As a result, final evaluation reports will provide more comprehensive and conclusive evidence about the effectiveness of the pilots' services, by examining individuals' experiences over a longer (three-year) follow-up period and examining the benefits of the pilot's new services relative to their costs.

Evaluation overview

The evaluation includes the following four components:

1. An ***implementation analysis*** that documents the context and operations of each pilot;
2. A ***participation analysis*** that examines the characteristics, participation levels, and service paths of individuals in the pilots;
3. An ***impact analysis*** that identifies 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; and
4. A ***cost analysis*** that describes the total and component costs of each pilot.[3]

The evaluation of each pilot used an experimental research design. As part of this design, the evaluation team randomly assigned individuals eligible for SNAP E&T who enrolled in the pilot into treatment and control groups. Treatment group members were eligible for an enhanced set of services developed under each pilot, and control group members were eligible for services available through existing SNAP E&T programs in the State; both groups continued to be eligible for other services available to anyone in their communities. Through random assignment, the characteristics of the groups were similar when they enrolled into the pilot, on average. This design allows the evaluation to confidently attribute any differences in outcomes between the groups to the enhanced SNAP E&T services rather than to other potential causes.

Sources of data used in the evaluation include administrative service use data to describe engagement and participation in services; unemployment insurance (UI) wage records to

[3] While this report presents analyses relating to each of these four components, the final reports will include additional analyses for two of the study components. The participation analysis will also assess whether the presence of the pilots affected people's decisions to apply for SNAP or to continue to receive SNAP benefits. The cost analysis will also include a cost-benefit analysis which estimates the return on each dollar invested in the pilots.

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; and 12-month follow-up survey data to provide additional information about individuals' service receipt, employment, and earnings, as well as food security, health, well-being, and housing status. The evaluation also used implementation data collected from interviews with pilot staff and treatment group members to describe the pilots and services, and grantee-provided cost data and time-use data to estimate the cost of services and service components.

Pilot overview

Across all pilots, the primary grantee who oversaw the pilots was the State SNAP agency. These agencies generally partnered with service providers—such as Workforce Innovation and Opportunity Act (WIOA) agencies, community-based organizations or other education or training providers, or community colleges—and non-provider partners—such as community-based organizations, leadership councils, or university boards or centers—to help provide services and administer the pilots. For most pilots, the grantee worked with some or all of their partners or providers to plan pilot processes and activities over most of 2015. The pilots then began enrollment between January 2016 and April 2016.

States and their partners and providers often utilized the pilots as opportunities to develop SNAP E&T services that provided more intensive services than were usually available, filling a gap in existing services. This could include offering more intensive case management, additional support services, work-based learning opportunities, or individualized services that were responsive to each person's specific needs. Some States expanded their SNAP E&T services to align with what they offered in other programs such as TANF or WIOA, while others created services that did not exist in the pilot areas.

Most of the pilots operated in select areas of the States (Exhibit ES.1). Pilots that did not offer services statewide generally targeted regions that were most in need of services, had the largest target populations, or had providers who could readily offer enhanced services. The areas served ranged from one county in California to 35 counties in Kansas. Most of the pilots were serving a mix of urban and rural communities.

Participation in seven of the pilots was voluntary, and three State SNAP agencies administered mandatory E&T programs in some or all of the pilot counties. In these E&T programs, mandatory individuals enrolled in the pilot were required to participate in E&T activities (either pilot activities or activities offered through the existing SNAP E&T program) to retain their SNAP benefits. Those who did not comply with requirements—in either the treatment or control group—were sanctioned for noncompliance, which means they lost their benefits and were ineligible to participate in SNAP (and the pilot) for a period of time determined by the State.

Exhibit ES.1. Pilot characteristics

State	Grantee agency	Location	Program type	Target population
California	California Department of Social Services and Fresno County Department of Social Services	Fresno County	Voluntary	Work registrants with an emphasis on families with children, those who were unemployed or underemployed, had a criminal history, had limited work experience, and those without a high school diploma
Delaware	Delaware Department of Health and Social Services, Division of Social Services	Statewide	Voluntary	New work registrants
Georgia	Georgia Division of Family and Children Services	9 counties in and near the Atlanta and Savannah metropolitan areas[a]	Mandatory	Able-bodied adults without dependents (ABAWDs)
Illinois	Illinois Department of Human Services	33 counties across seven local workforce investment areas (LWIAs)	Mandatory and voluntary	Unemployed or underemployed work registrants with low skills or limited work experience, including ABAWDs, and individuals working 30 or more hours per week but needing skill upgrades
Kansas	Kansas Department for Children and Families	35 counties	Voluntary	Work registrants
Kentucky	Kentucky Department of Community Based Services	8 rural counties in southeastern Kentucky (a Federal Promise Zone)	Voluntary	Work registrants
Mississippi	Mississippi Department of Human Services	29 counties	Mandatory	ABAWDs
Vermont	Vermont Agency of Human Services, Economic Services Division	Statewide	Voluntary	New work registrants with self-identified barriers including substance use disorders, mental health disorders, housing instability, and/or criminal histories
Virginia	Virginia Department of Social Services	24 localities served by 22 social service agencies and 7 community colleges	Voluntary	Work registrants
Washington	Washington Department of Social and Health Services	4 counties (King, Pierce, Spokane, Yakima)	Voluntary	New work registrants who were long-term unemployed, homeless, veterans, noncustodial parents with child support arrears, or who had barriers to employment, or limited English proficiency

[a]Pilot services were originally offered in 10 counties, but Georgia stopped offering pilot services to new participants in one county after January 2017.

The pilots were required to target primarily work registrants, but half of the pilots targeted just a subset of this population or also served additional groups. Two pilots targeted able-bodied adults without dependents (ABAWDs), who were mandatory participants in both States and expanded services could help them meet their work requirements. Two other pilots targeted individuals who had significant barriers to employment, such as those who are long-term unemployed or have substance use disorders, mental health disorders, criminal histories, or unstable housing.

Reflecting the variety of target groups, the characteristics of pilot enrollees differed by pilot. In six pilots, for example, individuals were more likely to be male than female. In only four pilots were more than 20 percent of enrollees living in households with children. Across the pilots, the average age of enrollees ranged between 31 and 39 and about one-quarter of enrollees did not have a high school diploma. Finally, three-quarters or more of individuals in each pilot were employed at some point during the five years before enrollment, but, at the time of enrollment, only 5 to 28 percent of all individuals were currently working.

The services, supports, and activities available to treatment group members varied across pilots. Services and supports 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, such as transportation assistance, housing assistance, and training or work supplies (for example, uniforms, books, clothes, or tools), that helped reduce barriers to engagement in the pilot and employment. A range of E&T activities was also offered, such as 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). The activities offered to the treatment group generally were more expansive than those offered under existing SNAP E&T programs which, in most States, tended to focus on less intensive job search assistance. Moreover, while the pilots were operating, existing SNAP E&T programs could not fund some of the activities and services the pilots provided to treatment group members, such as subsidized employment,[4] substance use disorder counseling, and mental health counseling.

Despite planning to offer a range of activities and services, pilots often emphasized just a subset of these in which they intended most individuals to participate. Most pilots offered some type of job search assistance or job search training, occupational skills training, or basic education—slightly fewer offered work-based learning activities, and all offered case management and support services (check marks in Exhibit ES.2). However, a smaller number of pilots focused primarily on each of these activities and services when identifying the two most prominent activities and services grantees intended to offer (cells highlighted in Exhibit ES.2). Pilots intended to offer occupational skills training (seven pilots) and job search assistance or training (five pilots) most frequently. Three pilots expected to focus on case management or basic education, and one focused on work-based learning or on providing support services. (Although

[4] The Agriculture Improvement Act of 2018 (P.L. 115-334) made subsidized employment an allowable SNAP E&T component, although States have to wait for final rulemaking before they can begin offering it as an E&T component.

all of the pilots offered case management and support services along with other activities, some pilots intended for these to be the most prominent services offered through their pilot, as identified in Exhibit ES.2.)

Exhibit ES.2. Activities and services pilots planned to offer to treatment group members at the start of the pilot and those intended to be most prominent

	Pilot activities				Pilot services	
Pilot	Job search assistance or training	Occupational skills training	Basic education	Work-based learning	Case management	Support services
California	✓	✓	✓	✓	✓	✓
Delaware	✓	✓		✓	✓	✓
Georgia	✓	✓	✓	✓	✓	✓
Illinois	✓	✓	✓	✓	✓	✓
Kansas	✓	✓	✓		✓	✓
Kentucky		✓	✓	✓	✓	✓
Mississippi	✓[a]	✓	✓	✓	✓	✓
Vermont	✓	✓	✓	✓	✓	✓
Virginia	✓	✓	✓		✓	✓
Washington	✓[a]	✓	✓	✓	✓	✓

Source: SNAP employment and training evaluation implementation data collection.

Note: The check marks represent the activities and services the pilots planned to offer to treatment group members at the start of the pilot. The highlighted cells represent the evaluation team's assessment of the two most prominent services pilots planned to offer, based on the pilot staff's description of plans for service delivery.

[a]Represents a structured up-front soft skills and life skills training course.

Evaluation findings

This section presents key findings from the main research components of the evaluation.

Implementation findings

All of the grantees developed services, created partnerships, and began enrolling individuals into their pilots within about one year of grant award. The amount of work required during the planning period was significant, but all grantees were able to begin pilot enrollment with most services in place despite some challenges during the planning period. Overall, the models were generally implemented as intended, with some changes made over time in response to emerging needs.

Several key findings emerged across pilots that reflect both strengths of the implementation and challenges pilots faced, which can provide lessons for implementing similar efforts:

- **Strategic partnering was important for most pilots but was also challenging.** SNAP agencies often were not able to provide particular services directly or existing SNAP E&T program providers did not offer a robust set of services. For these reasons, partnering was vital to be able to offer the expanded services. While partnerships with providers and non-providers were cited by pilot managers as major accomplishments, they were not without challenges for some grantees, which stemmed from issues around aligning organizational missions and approaches, a lack of clear and complete communication between organizations, or the time required to develop relationships and coordinate.
- **Developing and launching services that did not exist before the pilot was particularly challenging, even when partnering with established providers.** Although many of the pilots were expanding an existing set of services or adding services that were already being provided to other groups, a few pilots created entirely new services or provided services in areas where SNAP E&T services had not previously been available. These more extensive development processes were sometimes challenging and resulted in slower than planned implementation of specific activities or services.
- **Take-up and completion of education, occupational skills training, and work-based learning activities were often lower than pilot staff anticipated.** Several factors contributed to low take-up rates, including individuals' lack of interest in the offered services or willingness to enter lengthy trainings and challenges pilot staff faced in implementing certain activities (which limited the availability of those activities). Pilot staff also indicated that a number of pilot enrollees had barriers that sometimes interfered with participation in activities, including transportation, unstable housing, physical or mental health issues, substance use disorders, and lack of child care.
- **The service models sometimes inadvertently affected rates of take-up and completion of services**. In some pilots, pilot staff initially did not fully understand the characteristics or interests of the population targeted. Some models also had multiple "hand-off" points or upfront requirements before individuals could enter employment, education, and training activities, which often delayed activity participation. Finally, some models did not account for the flow of individuals into the pilot versus the timing of available activities—for example, community college programs that ran on a semester system—sometimes leading to waiting periods before individuals could start education or training activities.
- **Pilot staff viewed robust support services, particularly transportation assistance, as key to getting individuals into activities and keeping them engaged.** In many pilots both staff and individuals participating in the pilots frequently discussed the importance of support services in mitigating barriers to participation, so that participants could engage in activities and work toward their goals. However, even with the provision of extensive supports, some individuals had significant barriers that were not fully addressed, often related to transportation and housing.

Participation findings: Pilot services received by treatment group members

Although most individuals assigned to the treatment group (over 90 percent in six pilots) initially engaged in pilot activities—such as starting an assessment or developing an individualized career

plan—a smaller percentage eventually started an employment or training-related activity (Exhibit ES.3). Over the 12 months following their random assignment, between 40 and 90 percent of treatment group members in the 10 pilots started an employment and training-related activity (such as job search assistance or training, occupational skills training, basic education, or work-based learning). Although not all treatment group members participated in such activities, most received case management and many received support services.

Exhibit ES.3. Percentage of individuals who engaged in services and activities

	California	Delaware	Georgia	Illinois	Kansas	Kentucky	Mississippi: ECCS group	Mississippi: BCCS group	Vermont	Virginia	Washington
Initial engagement in the pilot	94	69	58	69	92	99	67	91	96	84	91
Started any employment and training-related activity	77	40	55	64	90	50	65	56	88	61	56
Job search assistance or training	70	31	49	28	59	--[a]	58	--[a]	71	46	46
Occupational skills training	25	11	5	43	17	27	24	27	25	18	13
Basic education	20	5	1	11	6	3	10	16	2	16	7
Work-based learning	2	3	0	28	--[a]	34	15	11	7	--[a]	1
Had contact with case manager	96	100	93	99	NA	96	64	75	86	94	94
Received a support service	39	59	25	54	74	70	87	82	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.

Take-up rates for specific pilot activities. Among employment and training-related activities, take-up was highest for job search assistance or training—45 percent or more of treatment group members in seven pilots participated in this type of activity (Exhibit ES.3). Fewer individuals participated in occupational skills training, but participation was 25 percent or higher in five pilots. More than 25 percent of individuals participated in work-based learning in only two pilots.

Case management and support services. Over 90 percent of treatment group members in seven pilots had at least one contact with a case manager (Exhibit ES.3). The percentage of individuals who received any type of support service varied; generally 50 to 70 percent of individuals across the pilots received a support service while in the pilot, most commonly transportation assistance.

Pilot exits. Exit rates were relatively high in most pilots, with 70 percent or more of treatment group members in seven pilots exiting within a year of random assignment (and three pilots had

exit rates of 90 percent or more; not shown in Exhibit). Of those who exited, most individuals left the pilot before completing services, or they became ineligible for the pilot due to losing SNAP benefits, beginning to receive TANF, or not complying with pilot rules and being terminated. Few individuals exited the pilot due to completing all pilot activities or finding employment (based on self-reporting).

Participation findings: Differences between treatment and control groups in service receipt

An examination of differences in service receipt between the treatment and control groups provides important context for interpreting the range of impacts across pilots on employment, earnings, and receipt of public assistance. Without a meaningful difference between treatment and control groups in the types and amounts of services received, impacts on labor market and public assistance outcomes are unlikely to result.

In each pilot, even though a substantial number of control group members participated in existing SNAP E&T services or community-offered services, the treatment groups were more likely than the control groups to participate in some type of activity. Differences were largest for general job skills training, a category that encompassed job readiness activities. Across the pilots, differences in the likelihood of treatment and control group members participating in such activities ranged from 6 to 27 percentage points. Differences were also apparent regarding participation in occupational skills training. Across the pilots, differences in the likelihood of treatment and control group members participating in such training ranged from 6 to 24 percentage points. Differences in participation in education were smaller (at least 10 percentage points in only four pilots), and few treatment-control differences were found for participation in work-based learning. Treatment group members were also more likely than control group members to receive an occupational certificate or license in all but one pilot by 3 to 16 percentage points. Relative to the control groups, the treatment groups also had higher rates of completion of activities and were more likely to receive case management and support services.

Impact findings: Short-term impacts on employment, SNAP participation, and other outcomes

The impact analysis focuses on whether the generally higher rates of service receipt among individuals in the treatment group, compared with the control group, translated into impacts on employment, earnings, and SNAP participation, and on other outcomes such as food security. We estimated the impacts of treatment group services on employment, earnings, and SNAP participation over the 12 months (4 quarters) following random assignment for each individual; we measured impacts on other outcomes one time at approximately 12 months after random assignment. Before analyzing the data, we selected two primary (confirmatory) outcomes: employment (based on both the UI and survey data) and SNAP participation—both in the fourth quarter after random assignment, which is the most recent observed quarter. The primary outcomes were defined over the final quarter of available data because many treatment group members were expected to be engaged in education and training shortly after random

assignment, thus possibly reducing their opportunity to be employed during those early quarters.[5] Pilots' enhanced services led to an increase in treatment group members' Quarter 4 employment rates compared with control group members in three pilots (California, Kansas and Kentucky). In two pilots, pilots' enhanced services led to a decrease in employment (Delaware and Virginia) (Exhibit ES.4). We found no program effects on Quarter 4 employment in the remaining five pilots. Similarly, Quarter 4 earnings were higher for treatment group members in two pilots and were lower in one pilot. In the majority of pilots, there was some indication of earnings growing faster over time for treatment group members than for control group members, likely reflecting individuals in the treatment group completing activities and becoming employed. Longer-term follow-up will help assess whether this trajectory continued and the employment and earnings of the treatment group overtook those of the control group.

Pilot services led to a decrease in the likelihood that treatment group members would participate in SNAP in Quarter 4 compared with control group members in one pilot and increased the likelihood of SNAP participation in four pilots (Exhibit ES.4). The increase in SNAP participation makes sense for pilots where both earnings and employment were lower for the treatment group relative to control group, which likely led to a higher rate of SNAP participation among the treatment group. In other pilots, the treatment and control groups had similar earnings over the follow-up year, resulting in no difference between groups in SNAP participation.

Finally, there were few impacts on food insecurity. In eight pilots, the services offered to the treatment group did not lead to a reduction in the percentage of individuals living in households that were food insecure 12 months after random assignment. This is not surprising, given that such reductions would be expected to result from increases in earnings, which were rare.

[5] Although the level of earnings was an important outcome in the evaluation, we excluded it from the set of primary outcomes due to the generally greater variation in earnings as opposed to employment, which results in lower statistical power when identifying an impact on earnings relative to employment. Effects on earnings are important to assess because they can affect both SNAP participation status and food security.

Exhibit ES.4. Summary of treatment–control differences in employment, earnings, and SNAP participation

	CA	DE	GA	IL	KS	KY	MS (ECCS)	MS (BCCS)	VA	VT	WA
Employment (using UI wage records) in Quarter 4	ns	-	ns	ns	+	+	ns	ns	-	ns	ns
Employment (using survey data) in Quarter 4	+	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Earnings (UI wage records) in Quarter 4	+	ns	ns	ns	+	ns	ns	ns	-	ns	ns
Earnings (survey) in Quarter 4	+	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
SNAP participation in Quarter 4	ns	+	ns	-	ns	ns	+	+	+	ns	+

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

Note: MS (ECCS) and MS (BCCS) refer to the differences between the ECCS and BCCS treatment groups in Mississippi and the control group. Indications for CA reflect differences between the CA treatment group and the CA "no service" control group.

+ indicates that difference between research groups is positive (treatment group estimates are higher than control group estimates) and statistically significant at the .10 level.

- indicates that difference between research groups is negative (treatment group estimates are lower than control group estimates) and statistically significant at the .10 level.

ns indicates that difference between research groups is not statistically significant at the .10 level.

Pilot cost findings

FNS awarded grants ranging from approximately $9 million to $22 million to States to cover States' costs associated with the pilots, covering the pilot planning period through the end of pilot service provision. The evaluation collected total costs from the grantee, partners, and providers that were funded by the grants and were funded through other means to pay for pilot-related administration and direct service costs. Through December 2017, the States reported spending from $4 to $16 million on planning and implementing treatment group services. Most of the costs were allocated to administration (activities not related to direct services), including pilot planning and development, management and oversight, and recruitment and enrollment; 7 of 10 grantees spent more than half of total costs through December 2017 on administrative activities. The remaining costs were for direct services. The proportion of total costs represented by direct service costs will likely increase when costs beyond December 2017 are considered.

Conclusion

The goal of the 10 SNAP E&T pilots was to provide enhanced services meant to increase SNAP participants' employment and earnings and reduce their need for nutrition assistance benefits. This interim summary report presents preliminary evaluation findings covering one year of follow-up for all 10 pilots using survey and administrative data.

Several key findings have emerged at this interim point in the evaluation:

- Developing services, creating partnerships, and beginning enrolling individuals within a year of grant receipt were accomplishments, but many States experienced challenges related to offering new services and promoting take-up and completion of education, occupational skills training, and work-based learning activities.
- Pilot staff viewed developing strategic partnerships and providing robust support services, particularly transportation assistance, as beneficial aspects of the pilots.
- Most treatment group members met with a case manager and conducted intake assessments, and many received support services (although the rates varied across the pilots). Participation in employment and training-related activities was lower in comparison.
- Most individuals left the pilots within one year, frequently within six months, and often before they completed activities.
- Compared to control group members, treatment group members were more likely to participate in and complete employment and training-related activities and to receive case management and support services.
- So far, few positive impacts on employment have emerged during this short-term, 12-month follow-up period. The evaluation found evidence treatment group members were more likely to be employed in Quarter 4 compared to the control group in three pilots and less likely to be employed in two pilots. However, there is some indication that earnings grew faster over time for treatment group members than for control group members in several pilots.
- Pilot activities generally did not decrease the likelihood of SNAP participation. Rather, in several pilots the treatment group was more likely than the control group to participate in SNAP in Quarter 4.
- The majority of early pilot costs (prior to 2018) related to planning and administering the treatment services. The share of total costs associated with providing direct services, as opposed to planning or administration, will likely increase by the end of the pilots.

The interim findings related to SNAP participation generally are intuitive given the patterns of changes in earnings and employment over the first follow-up year for treatment and control group members. SNAP E&T services are designed to increase individuals' employment and earnings and, thus, reduce their need for SNAP or other public assistance. Over the 12-month follow-up period examined in this report, the enhanced set of services provided by most pilots did not lead to increased employment or earnings; therefore, we would not expect treatment group members in those pilots to be able to leave SNAP at higher rates than would be possible for control group members.

These findings do not imply that the services provided to the treatment group in each pilot will not eventually be effective in increasing employment and earnings and reducing individuals' need for SNAP benefits. In fact, past studies of workforce programs have shown it can take more than a year before economic impacts emerge (Card et al. 2010, 2018; D'Amico et al. 2015). Indeed, treatment group members' participation in education and training activities was highest

in the early quarters of follow-up in most pilots, likely displacing employment during this period. Results from a longer-term follow-up period, which will extend up to three years from random assignment, are needed to fully assess the impacts of these services.

Final report

Findings in this report cover only the first 12 months after each individual was randomly assigned. Some individuals continued to receive services past this point, and pilots continued to enroll and provide services through 2018 and, in some cases, into 2019, beyond the study period of this interim report. Furthermore, the report's cost findings cover only the pilot planning and early implementation periods. A final report will examine the experiences of all individuals enrolled in the pilots, present their outcomes over a follow-up period of up to 36 months after random assignment, and examine the benefits of the pilots' new services relative to their full costs. In doing so, the final report will provide comprehensive and conclusive evidence about the effectiveness of the pilots.

I. INTRODUCTION

The Supplemental Nutrition Assistance Program (SNAP) is the primary source of nutrition assistance for many low-income individuals and families. The program provides monthly benefits to help SNAP participants obtain adequate access to food, but for some in the program, it also provides work supports to help them become self-sufficient. As part of SNAP, States administer SNAP Employment and Training (E&T) programs, which assist SNAP participants in obtaining meaningful employment by providing (1) services, such as job search assistance, job skills training, education, or work experience and (2) supports, such as assistance with transportation or child care costs.

Despite the importance of SNAP E&T, information about approaches that most effectively connect SNAP participants to gainful employment is limited. For this reason, as part of the Agricultural Act of 2014, Congress authorized and funded pilots to test innovative strategies to connect 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) made awards to grantees in 10 States—California, Delaware, Georgia, Illinois, Kansas, Kentucky, Mississippi, Vermont, Virginia, and Washington—which represented diverse areas and populations.[6] Pilots varied in whether they operated statewide or were limited to select areas within a State, and whether they focused on urban communities, rural communities, or both. Most pilots targeted work registrants who were unemployed or underemployed,[7] but other pilots focused on individuals with significant barriers to employment, such as being homeless or having a criminal history or substance use disorder. Pilots also varied in the services they offered, but services typically included a skills and/or clinical assessment that determined individuals' work readiness, skills, and barriers to employment; case-management services that developed and supported a detailed and individualized work and barrier-reduction plan for individuals; and support services, such as transportation assistance, housing assistance, and training and work supplies that supported individuals' involvement in activities designed to reduce barriers to employment. Offered services also included a range of E&T activities, such as job readiness training, basic education, occupational skills training, and subsidized employment, although not every pilot offered all of these services. Each pilot enrolled 3,000 to 7,000 individuals over a one and half year to two and a half year period for a total of 44,359 individuals

[6] SNAP in California is county administered and only Fresno County was conducting the pilot; however, the FNS grant was awarded to the State SNAP agency. The State oversaw the pilot, but Fresno County primarily administered it. Although Fresno County led the pilot, to align with how we refer to other pilots, we will refer to the Fresno pilot as California.

[7] Work registrants are SNAP participants who have not met any Federal exemptions from SNAP work requirements and are therefore required to, among other things, 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.

across the 10 pilots. The legislation that authorized the pilots also included funding for a rigorous, longitudinal evaluation to assess impacts of the pilots on participants' outcomes.

This report synthesizes findings from 10 State-specific interim reports to provide a general assessment of how the pilots were implemented, what services individuals enrolled in the pilots received, and whether these services led to impacts on individuals' employment, earnings, and participation in SNAP, among other outcomes.[8] The service receipt and impact findings are based on data covering a one-year follow-up period.

In the remainder of this chapter, we provide an overview of the evaluation (Section A) and summarize the data sources and analytic approach used in conducting the evaluation (Sections B and C). In Section D, we present a road map to the subsequent chapters of this report.

A. Objectives of the evaluation

The interim evaluation includes the following four components:

1. An ***implementation analysis*** that documents the context and operations of each pilot;
2. A ***participation analysis*** that examines the characteristics, participation levels, and service paths of individuals in the pilots;
3. An ***impact analysis*** that identifies 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; and
4. A ***cost analysis*** that describes the total and component costs of each pilot.

A challenge for any impact analysis is that individuals who receive services might differ from those who do not receive services. This makes it difficult to determine whether differences in outcomes are a result of the services or are driven by pre-existing differences between individuals who did or did not receive services. To overcome this challenge, the evaluation of each pilot used an experimental research design in which individuals eligible for SNAP E&T who enrolled into the pilot were randomly assigned into treatment and control groups that were offered differing arrays of services.[9] Treatment group members were eligible for an enhanced set of services developed under each pilot, and control group members were eligible for services available through existing SNAP E&T programs in the State; both groups continued to be

[8] We will add a citation or link to the 10 reports if they are released before or around the same time as the summary report.

[9] With the exception of California and Mississippi, each pilot had one treatment group and one control group. However, California had one treatment group and two control groups: the Existing Services (ES) control group was eligible for services available through the existing SNAP E&T program in the State, and the No Services (NS) control group did not receive existing SNAP E&T services. Mississippi had one control group and two treatment groups: the Enhanced Community College Services (ECCS) group and the Basic Community College Services (BCCS) group. In addition to the services offered to the BCCS group, the ECCS group was offered a four-week career readiness course and more intensive case management.

eligible for other services available in their communities. Through random assignment, the research (treatment and control) groups within a pilot were, on average, similar in all aspects when they enrolled. They differed only in terms of the services they subsequently were eligible to receive. This design allowed the evaluation to confidently attribute differences in outcomes between the two groups to the enhanced services rather than to other potential causes.

B. Data sources

Data used in the interim evaluation reports were collected from many sources, described below. The specific time periods covered by these data vary across pilots due to differences in data availability and pilot enrollment periods.[10] The time periods covered in each data set are presented by pilot in Appendix Table A.1. The numbers of treatment and control group members included in each analysis are presented by pilot in Appendix Table A.2.

1. **Baseline registration form.** Baseline data were collected for all individuals at pilot enrollment and included their demographic characteristics, employment histories, and receipt of public assistance.
2. **Implementation data.** Pilot implementation data were collected during two rounds of site visits that included interviews with staff from the grantee agency, local offices, and service providers; structured observations of service provider operations; and in-depth interviews and focus groups with treatment group members. We also used information obtained during technical assistance and monitoring site visits and telephone calls conducted during the planning period and throughout the interim analysis period.
3. **Administrative service use data.** Grantees and local agencies provided administrative data that documented the types of training, education, and other services they provided to treatment group members.
4. **Unemployment insurance (UI) wage records.** Data on employment status and earnings were obtained from State UI wage records. Data were obtained for each individual for eight quarters (two years) before the date of random assignment and for four quarters after random assignment.
5. **SNAP administrative data.** SNAP administrative caseload data were obtained from grantees and used to construct measures of receipt of SNAP, Temporary Assistance for

[10] The start of enrollment varied across pilots from January to April 2016. Although enrollment continued past December 2017 in most pilots, the availability of data at the time the interim evaluation reports were prepared required the analyses in the reports to include individuals enrolled before 2018. For most pilots and data sets, this allowed the evaluation to assess individuals' service receipt and outcomes over a one-year follow-up period after their enrollment. In some pilots, data availability at the time the interim reports were prepared did not permit a full 12 months of follow-up for all individuals who enrolled in the pilot before 2018. In the case of the service receipt analysis and the analysis of pilot impacts using SNAP administrative records, this resulted in a small number of late-enrolling individuals in some pilots having slightly less than 12 months of follow-up. In the case of the analysis of pilot impacts using unemployment insurance wage records, the evaluation team shortened the cohort used in the interim report analyses in most pilots so that all individuals included in the analysis had a full year of employment and earnings follow-up.

Needy Families (TANF), and Medicaid; SNAP and TANF benefit amounts; and income, and to characterize individuals' recent history of SNAP participation.

6. **12-month follow-up survey.** Telephone surveys were conducted with individuals at about 12 months after random assignment. The survey asked for information about individuals' service receipt, employment, and earnings in the 12 months after random assignment. It also asked about food security, health, well-being, and housing status.
7. **Cost data.** Pilot grantees, partners, and providers completed cost workbooks,[11] which were used to calculate total costs and describe the categories of costs for the treatment groups, including costs for staff, direct services, supplies and equipment, and overhead and operations. A staff time-use survey helped estimate the costs of service components by accounting for how staff responsible for providing direct treatment group services spent their time.

C. Analysis approach

The findings presented in this report are based on a comprehensive set of analyses of interim data:

1. **Implementation analysis.** The implementation analysis summarizes and synthesizes site visit data to describe pilot planning and operations through mid-2017.
2. **Participation analysis.** The participation analysis uses administrative service use data to summarize the treatment groups' participation in services developed under each pilot over the 12 months following random assignment.
3. **Analysis of differences in service use between treatment and control groups.** This analysis statistically compares receipt of services between treatment and control group members over the 12 months following random assignment using survey data that were collected consistently for both research groups. The analysis examines receipt of any type of service, regardless of whether it was provided through the pilot or existing SNAP E&T, or whether it was generally available in the community, through programs such as ones funded by the Workforce Innovation and Opportunity Act (WIOA) or provided by community colleges, nonprofits, or other organizations. Understanding the differences in service use between the treatment and control groups provides context for understanding the impacts on employment, earnings, and receipt of public assistance.
4. **Analysis of impacts on employment and other outcomes.** We estimated the impacts of pilot services on individual outcomes over the 12 months following random assignment using both survey and administrative records data. Primary outcomes are employment and SNAP participation; other outcomes include earnings, food security, health, well-being, and housing status.[12] With an experimental design, unbiased impact estimates are attainable from the differences between average outcomes of the treatment and control groups. However, we

[11] Partners are organizations that helped the grantee oversee and administer the pilot but did not provide direct services to individuals, which was the role of providers.

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

used regression procedures that controlled for individual characteristics that were predictive of the primary outcomes to improve the precision of estimates and adjust for small baseline differences between groups that arose by chance, due to survey nonresponse, or from missing administrative records data.

5. **Cost analysis.** We used the "ingredient" approach to build up total cost estimates from all reported direct and in-kind costs. We also used data on the percentage of time direct service staff spent on key activities and services to estimate the cost of specific services.[13]

Additional details on the data and methodology used to conduct these analyses are in each of the 10 State-specific interim reports.

D. Overview of key findings

The following are key interim report findings for the four evaluation components:

- **Implementation.** Most states successfully developed services, created partnerships, and began to enroll individuals within a year of receiving their grant, which was a notable accomplishment. Grantees generally implemented pilot models as intended, while making some adjustments over time to respond to treatment group members' and staff's needs. Despite these achievements, most pilots faced challenges during the planning and early implementation periods that likely affected how well the pilots were implemented and the outcomes of individuals enrolled in the pilots. These included challenges related to strategic partnering, developing and launching new services, and promoting take up and completion of education, occupational skills training, and work-based learning activities.
- **Service receipt.** In most pilots, almost all individuals in the treatment group met with a case manager or outreach specialist, started an assessment, or received a support service. Despite high rates of initial engagement, generally fewer treatment group members eventually started an employment or training-related activity after they completed intake and assessment within 12 months of enrollment. A small percentage of individuals in most pilots received a credential, certification, or degree within this 12-month follow-up period and many individuals left the pilots within six months after enrollment, before completing services.
- **Impact.** Although the treatment group was more likely than the control group in each pilot to start and complete job search training activities and education and occupational skills training activities, the treatment group services led to few increases in employment and decreases in the likelihood of participation in SNAP within 12 months of enrollment; rather, the services increased the likelihood of participation in SNAP in four pilots. These findings do not imply that the treatment group services in some pilots ultimately will not be effective in achieving the goal of increasing employment and reducing the need for public assistance, as longer-term results are needed to fully assess the impacts of these services.

[13] The final report will present the final costs for services, as well as a benefit-cost analysis, which will compare benefits and costs for the treatment and control group members, from the perspectives of individuals, government, and society.

- **Cost.** Grantees and their partners and providers reported spending a total of about $4 to $16 million from April 2015 to December 2017 on the planning and early implementation of treatment group services. Seven of the ten grantees spent more than half of total costs on administration activities. The remaining costs were for direct services and represented between 14 percent and 75 percent of total costs. Direct service costs likely will represent a larger share of total costs when costs throughout the entire pilot operational period—including 2018 and 2019 expenditures—are analyzed and reported.

This report summarizes findings from interim reports prepared for each of the 10 pilots. These reports present service use and short-term effects for individuals enrolled in the pilots between early 2016 and the end of 2017, and measure service use and effects over a 12-month follow-up period, starting from each individual's pilot enrollment date. However, the full effects of the new services might not have materialized during this short-term, 12-month follow-up period, especially for some individuals (8 to 29 percent of treatment group members, depending on the pilot) who were still receiving services at the 12-month point. In addition, some pilots continued to enroll and provide services to individuals in 2018 and 2019. Final evaluation reports will provide comprehensive and more conclusive evidence about the effectiveness of the pilots' services by examining the outcomes of all individuals enrolled in the pilots over a period of up to 36 months after random assignment. The final reports will also examine the benefits of the pilot services relative to their costs.

E. Organization of this report

The remainder of this report is organized as follows:

- Chapter II describes characteristics of the pilots, summarizes each pilot model, and compares offered services and activities.
- Chapter III presents a cross-site synthesis of the most common and relevant planning and early implementation findings from the pilots.
- Chapter IV presents findings from the participation analysis, describing the services that individuals in the treatment group received during their first year after random assignment.
- Chapter V describes differences between research groups in the receipt of services during the 12-month follow-up period.
- Chapter VI presents short-term impacts of the pilot services on individuals' outcomes.
- Chapter VII describes the variation across pilots in the costs of pilot planning and providing early services.
- Chapter VIII offers conclusions and describes what the final evaluation report will include.

II. CHARACTERISTICS OF PILOTS

This chapter describes key characteristics of the 10 pilots at the time the pilots launched. It also summarizes each pilot model and compares the key services and activities that each offered under the pilot.

For all pilots, the grant was awarded to the State SNAP agency. These agencies generally partnered with service providers—such as Workforce Innovation and Opportunity Act (WIOA) agencies, community-based organizations or other community education or training providers, or community colleges—and non-provider partners—such as community-based organizations, leadership councils, or university boards or centers—to help provide services and administer the pilots (Exhibit II.1). For most pilots, the grantee worked with some or all of its partners and providers to plan pilot processes and activities over most of 2015 after grants were awarded in March of that year. States began enrolling individuals into their pilots between January 2016 and April 2016.

When applying for the pilot grants, the grantees and their partners and providers often saw the pilots as an opportunity to develop and provide more intensive services than were currently available or to provide services in areas where SNAP E&T was not available, filling a gap in existing services. This could include offering more intensive case management, additional support services, work-based learning opportunities, or individualized services that were responsive to each person's specific needs. Some States were expanding their SNAP E&T services to align with what they offered in other programs such as Temporary Assistance for Needy Families (TANF) or WIOA, while others were creating services that did not exist in the pilot areas.

Participation in the majority of the pilots was voluntary, and three State SNAP agencies—Georgia, Illinois, and Mississippi—administered mandatory E&T programs in some or all of the pilot counties (Exhibit II.1). In these E&T programs, mandatory individuals enrolled in the pilot were required to participate in E&T activities (either pilot activities or activities offered through the existing SNAP E&T program) to retain their SNAP benefits. Those who did not comply with requirements—in either the treatment or control group—were sanctioned for noncompliance, which means 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 States, but Delaware and Vermont offered services statewide (Exhibit II.1). Pilots that did not offer services statewide generally targeted regions that were most in need of services, had the largest target populations, or had providers who could readily offer enhanced services. The areas served ranged from one county in California to 35 counties in Kansas. Most of the pilots were serving a mix of urban and rural communities, but pilots in Kentucky and Vermont targeted primarily rural areas.

Exhibit II.1. Key characteristics of pilots

State/pilot name	Grantee agency	Key partners and providers	Program type	Location	Target population
California/ California Bridge Academy (CBA)	California Department of Social Services and Fresno County Department of Social Services	Reading and Beyond, Fresno County Economic Development Corporation	Voluntary	Fresno County	Work registrants, including families with children, those who were unemployed or underemployed, had a criminal history, had limited work experience, and those without a high school diploma
Delaware/ Work Opportunity Networks to Develop Employment Readiness (WONDER)	Delaware Department of Health and Social Services, Division of Social Services	Eastside Rising, Food Bank of Delaware, Delaware Technical Community College, KraftHeinz, and Career Team	Voluntary	Statewide	New work registrants
Georgia/ SNAP Works 2.0	Georgia Division of Family and Children Services	Georgia Department of Labor, three Local Workforce Investment Agencies: DeKalb Workforce Services, Atlanta Regional Commission, Coastal Workforce Services	Mandatory	9 counties in and near the Atlanta and Savannah metropolitan areas[a]	Able-bodied adults without dependents (ABAWDs)
Illinois/ Employment Opportunities, Personalized Services, Individualized Training, Career Planning (EPIC)	Illinois Department of Human Services	Illinois Department of Commerce and Economic Opportunity, Southern Illinois University Center for Workforce Development, and 24 community-based organizations (providers)	Mandatory and voluntary	33 counties across seven local workforce investment areas (LWIAs)	Work registrants who are unemployed or underemployed with low skills or limited work experience, and individuals working 30 or more hours per week but needing skill upgrades
Kansas/ Generating Opportunities to Attain Lifelong Success (GOALS)	Kansas Department for Children and Families	University of Kansas, Center for Partnerships in Research	Voluntary	35 counties	Work registrants

Exhibit II.1. Key characteristics of pilots *(continued)*

State/pilot name	Grantee agency	Key partners and providers	Program type	Location	Target population
Kentucky/ Paths 2 Promise (P2P)	Kentucky Department of Community Based Services	Eastern Kentucky Concentrated Employment Program, Kentucky Adult Education, Kentucky Community and Technical College System, and Jobs for the Future	Voluntary	8 rural counties in southeastern Kentucky (a Federal Promise Zone)	Work registrants
Mississippi/ Ethics, Discipline, Goals, Employment (EDGE)	Mississippi Department of Human Services	Mississippi State University's 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, and Jobs for Mississippi Graduates	Mandatory	29 counties	ABAWDs
Vermont/ Jobs for Independence (JFI)	Vermont Agency of Human Services, Economic Services Division	Vermont Division of Vocational Rehabilitation, Vermont Department of Labor, Community Colleges of Vermont, and Community Action Agencies of Vermont	Voluntary	Statewide	New work registrants with self-identified barriers including substance use disorders, mental health disorders, housing instability, and/or criminal histories
Virginia/ EleVAte SNAP E&T	Virginia Department of Social Services	Virginia Community College System	Voluntary	24 localities served by 22 social service agencies and 7 community colleges	Work registrants
Washington/ Resources to Initiate Successful Employment (RISE)	Washington Department of Social and Health Services	Washington Employment Security Department, Washington Division of Child Support, the State Board of Community and Technical Colleges, local workforce development councils, 21 community-based organizations, and three community and technical colleges	Voluntary	4 counties (King, Pierce, Spokane, Yakima)	New work with significant barriers to employment: long-term unemployed, homeless, limited English proficiency, veterans, and noncustodial parents with delinquent payment history

[a]Pilot services were originally offered in 10 counties, but Georgia stopped offering pilot services to new participants in one county after January 2017.

The pilots were required to target primarily work registrants, but half of the pilots targeted just a subset of this population or also served additional groups. Georgia and Mississippi targeted able-bodied adults without dependents (ABAWDs), as these individuals were mandatory participants in both States and these services could help this group meet their work requirements. Vermont and Washington targeted individuals who had significant barriers to employment, such as individuals with long-term unemployment, substance use disorders, mental health disorders, criminal histories, or unstable housing. Finally, Illinois offered services to individuals working 30 or more hours per week but needing skill upgrades, in addition to work registrants.

Exhibit II.2 describes the individuals enrolled in the pilot in each site (treatment and control group members combined). Site variation in the individuals' characteristics reflects the diversity of the populations targeted in each pilot. The percentage of individuals who were female, for example, varied from 35 percent in Illinois to 74 percent in Virginia, and the average age of individuals varied from 31 in Mississippi to 39 in Vermont. The percentage of individuals who reported being currently employed at the time of enrollment ranged from 5 percent in Mississippi to 28 percent in Virginia. Almost all individuals had some work experience at the time of enrollment, ranging from 88 percent in Mississippi to 98 percent in Kansas.

Exhibit II.2. Characteristics of individuals at enrollment

Characteristic	CA	DE	GA	IL	KS	KY	MS	VT	VA	WA
Female (percent)	60	42	48	35	61	59	47	44	74	43
Average age (years)	35	34	33	34	37	33	31	39	37	38
Age less than 30 years (percent)	37	40	41	39	29	45	48	28	30	28
Married or cohabiting (percent)	17	7	4	4	14	30	28	11	11	11
Living in household with children (percent)	47	19	5	10	42	50	3	14	55	19
Without a high school diploma (percent)	25	24	21	23	23	25	31	19	20	27
Currently employed (percent)	22	12	6	7	16	14	5	14	28	8
Worked in past five years (percent)	82	92	88	79	91	78	81	84	85	78
Currently or ever employed (percent)	93	97	94	89	98	91	88	97	94	91

Source: SNAP E&T random assignment system (January 2016 through December 2017 data).

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 (N = 38,610).

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

Existing SNAP E&T programs: States that offered an existing SNAP E&T program generally provided a limited set of services (such as case management or support services) or activities (the services that individuals engage in such as training or education programs; Exhibit II.3). Most programs tended to focus on independent or structured job search (job search assistance and job placement) and workfare, but existing SNAP E&T programs in five pilot States—California (ES control group), Illinois, Kansas, Mississippi, and Washington—also offered education and occupational skills training activities to individuals in SNAP E&T. Generally only a small

proportion of eligible individuals participated in these activities, however. All of the existing SNAP E&T programs in the 10 pilot States offered some level of case management and support services, but case management often focused on intake and compliance, and supports were generally small transportation payments (about $25 per person per month in most States). Kentucky did not have a SNAP E&T program in any of the pilot counties, and Georgia, Illinois, Kansas, and Virginia did not offer E&T services in some pilot areas before or during the pilot.

Pilot services and activities: FNS did not specify the type of service model States needed to develop for the pilots, nor did they require States to incorporate specific services or activities into their models.[14] States had considerable flexibility in designing their pilot models, services, and activities; however, FNS wanted to fund and evaluate innovative strategies that offered activities beyond job search assistance or placement activities. These innovative models included offering pilot tracks, which individuals entered based on interests or requirements. For example, Delaware offered three industry-focused tracks and a fourth focused on employment placement, while Virginia offered a set of services through three tracks with eligibility 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 (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 months (Vermont and Washington). Finally, other pilots provided services through less structured models that packaged services and activities together based on each individual's needs and interests. Exhibit II.3 provides details on the key services each pilot offered through their pilot models; Appendix tables B.1 to B.10 illustrate the service model for each pilot.

Most of the pilots also included more services than were offered under existing SNAP E&T programs including intensive case management and additional support services. Pilots generally offered intensive case management, but the definition of intensive case management varied across pilots. Some pilots required case managers to hold weekly or monthly check-ins with individuals. In addition, the models used for providing case management varied. Many pilots used WIOA staff or other provider staff to conduct intake and check-ins, who used similar procedures as they would normally conduct with anyone obtaining services at their organization, but some pilots revised their intake and assessment process to focus on barriers and trained staff to help individuals mitigate those barriers. Other pilots used a team-based approach or hired clinical social workers to provide clinical assessments and case management to individuals. Although existing SNAP E&T programs offer support services (mainly transportation and child care assistance, which are mandated), the pilots generally offered more generous supports and a wider array of them such as housing, personal care items (such as eyeglasses or dentures), and occupational skills training or work supplies (for example, uniforms, books, clothes, or tools). The supports offered sought to help individuals reduce their barriers to employment and to 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 would

[14] States are required under law to provide transportation and child care assistance to individuals participating in activities if an absence of these supports would prevent the individual from participating.

cover all or most training or work-related costs. Other pilots provided supports less frequently or only once individuals had explored all other options to mitigate their barriers (such as getting a ride from a friend to get to training or trying to find housing with a family member before obtaining assistance from the pilot).

Exhibit II.3. Description of existing SNAP E&T program service (control) and key pilot services (treatment), by pilot

Pilot	Existing SNAP E&T (control) services	Key pilot (treatment) services
California	*ES group:* Case management, assistance connecting individuals to education and occupational skills training, job search assistance, and wraparound support services for members of the individual's family *NS group:* No SNAP E&T services available	Intensive case management, basic and postsecondary education, occupational skills training, subsidized employment, job search assistance, support services, job retention services, financial incentives for skill upgrades, and service retention
Delaware	Limited services through its voluntary SNAP E&T program; the control group received Career Team services, which included basic case management, job search assistance, workfare for ABAWDs, job placement assistance, and support services	Four tracks: three tracks included industry-specific training and employment (construction, culinary, and manufacturing with subsidized employment); the fourth track offered primarily job placement. Job readiness assistance, financial literacy counseling, criminal background remediation, and support services were available
Georgia	Limited services through its existing SNAP E&T program, primarily independent job search services and support services	Job search preparation and training, job search assistance, job readiness workshops, occupational skills training, case management, and support services
Illinois	No existing SNAP E&T services were available in 18 pilot counties; in the other 15 pilot counties (including Cook County), Illinois offered limited services through its existing SNAP E&T program. Services included access to adult basic education and General Education Diploma (GED) services, occupational skills training, unsubsidized work experience, and support services	Assessment and career exploration; case management; adult basic education, and GED services; occupational skills training; paid work experience, on-the-job training, and subsidized work; job readiness and job search assistance, job retention services; and support services (transportation assistance, uniforms and work-related supplies)
Kansas	Limited services through its existing voluntary SNAP E&T program (except in the Southeast region where SNAP E&T was not available), including limited occupational skills training, primarily in Certified Nursing Assistantships, potential referrals to GED services and local workforce development centers for training, and 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; mental health and substance use disorder counseling; job retention services; and support services

Exhibit II.3. Description of existing SNAP E&T program service (control) and key pilot services (treatment), by pilot *(continued)*

Pilot	Existing SNAP E&T (control) services	Key pilot (treatment) services
Kentucky	No services available; Kentucky did not offer SNAP E&T in the pilot counties before or during the pilot	Coordinated team-based case management, basic adult education, postsecondary education, occupational skills training, subsidized work-based learning opportunities, coaching while in training or employment settings, and a wide variety of support services provided to meet individuals' needs
Mississippi	Limited services through its mandatory SNAP E&T program; the control group received 30 days of up-front job search followed by workfare, plus transportation support. Tuition assistance and GED classes were available in some counties	*ECCS group:* a four-week career readiness class; intensive case management; three pathways—academic (basic education or occupational skills training), life skills (additional work or behavioral skills), or work (subsidized or unsubsidized employment or internships); and support services *BCCS group:* three pathways, support services, and more limited case management
Vermont	Limited services through its voluntary SNAP E&T program; the control group received Vermont Department of Labor services, which included basic case management, job search assistance, workfare for ABAWDs job placement assistance, and support services	Clinical assessment and counseling, a wide variety of support services to reduce individuals' barriers, referral to employment services with a Vocational Rehabilitation counselor or Department of Labor case manager, and referral to classes through Community Colleges of Vermont to obtain a Governor's Career Readiness Certificate
Virginia	No existing SNAP E&T services were available in 12 localities; in the other 12 localities, control group members could receive limited case management, job search assistance, and 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, and a wide variety of support services provided to meet individuals' needs
Washington	Job readiness training, basic skills/English as a Second Language training, occupational skills training, job search assistance, job placement, and support services	Comprehensive case management, a wide variety of support services provided to reduce individuals' 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), in addition to all available existing SNAP E&T services

ES group = Existing services control group in California

NS group = No services control group in California

ECCS group = Existing Community College Services treatment group in Mississippi

BCCS group = Basic Community College Services treatment group in Mississippi

Although the pilot models differed across the States, the activities and services available to individuals were of similar types. Most pilots planned to offer some type of job search assistance

or job search training, occupational skills training, or basic education (check marks in Exhibit II.4). Slightly fewer intended to offer work-based learning activities, and all pilots planned to offer case management and support services.

Despite planning to offer a range of activities and services, pilots often emphasized just a subset of these in which they intended most individuals to participate. Exhibit II.4 shows the two most prominent activities and services grantees intended to offer (highlighted cells).[15] Pilots planned to primarily offer occupational skills training (seven pilots) and job search assistance or job search training (five pilots) most frequently. Three pilots expected to focus on case management or on basic education, and one focused on work-based learning or on providing support services. (Although all pilots offered case management and support services along with other activities, some pilots intended for these to be the most prominent services offered through their pilot, as identified in Exhibit II.4.)

Exhibit II.4. Activities and services pilots planned to offer to treatment group members at the start of the pilot and those intended to be most prominent

	Pilot activities				Pilot services	
Pilot	Job search assistance or training	Occupational skills training	Basic education	Work-based learning	Case management	Support services
California	✓	✓	✓	✓	✓	✓
Delaware	✓	✓		✓	✓	✓
Georgia	✓	✓	✓	✓	✓	✓
Illinois	✓	✓	✓	✓	✓	✓
Kansas	✓	✓	✓		✓	✓
Kentucky		✓	✓	✓	✓	✓
Mississippi	✓[a]	✓	✓	✓	✓	✓
Vermont	✓	✓	✓	✓	✓	✓
Virginia	✓	✓	✓		✓	✓
Washington	✓[a]	✓	✓	✓	✓	✓

Source: SNAP employment and training evaluation implementation data collection.

Note: The check marks represent the activities and services the pilots planned to offer to treatment group member at the start of the pilot. The highlighted cells represent the evaluation team's assessment of the two most prominent services pilots planned to offer, based on the pilot staff's description of plans for service delivery.

[a]Represents a structured up-front soft skills and life skills training course.

[15] The evaluation team identified the two most prominent planned activities or services, based on the pilot staff's description of plans for service delivery during implementation data collection.

III. KEY CROSS-SITE IMPLEMENTATION FINDINGS

This chapter presents a cross-site synthesis of planning and early implementation findings from the pilots. The information is based on analysis of qualitative data collected through telephone calls and in-person interviews with pilot staff from the State agencies, partners, and providers, and focus groups conducted with individuals participating in treatment services. Findings discussed in this chapter are based on data collected from March 2015 through July 2017.

From the time the grants were awarded to the start of pilot enrollment was about 10 to 12 months for most of the grantees, during which time many were developing new partnerships, creating service models, developing new activities, and hiring pilot staff in the ramp up to implementation. The amount of work required during this period was significant, but all grantees were able to begin pilot enrollment with most services in place despite some challenges at the end of the planning period. Overall, the models were generally implemented as intended, with some changes made over time in response to emerging needs.

Many of the treatment group members across pilots initially engaged in the pilot and took-up some activities and services, despite take-up not being as high as expected for certain activities. A majority of individuals in most pilots met with case managers after random assignment and completed assessments and intake services. At least 50 percent of individuals started an employment or training-related activity in most of the pilots, and some pilots had take-up rates for starting any activity of more than 75 percent, such as California, Kansas, and Vermont.

Despite these achievements, most pilots faced challenges during the planning and early implementation periods that likely affected how the pilots were implemented and the outcomes of individuals enrolled in the pilots.[16] Several key findings emerged across pilots in this early period. These findings include both strengths of the implementation and challenges pilots faced, which can provide lessons for implementing similar efforts. These findings are:

1. **Strategic partnering was important for most pilots because SNAP agencies often were not able to provide particular services directly or existing SNAP E&T program providers did not offer a robust set of services. However, partnering also was not without its challenges.** Pilot staff often cited partnerships with providers and non-providers as one of their major accomplishments and also one of the biggest challenges. Partnerships were important for the pilots because the partners and providers often reached out to the target population, provided direct services in the community, or helped 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 were already providing. None of the pilots used SNAP eligibility staff to provide activities, but pilots such as Illinois and Mississippi used eligibility staff to conduct

[16] The findings in this report identify the early implementation challenges. Grantees and providers continued to make adjustment to the pilot process and services after this period to address challenges. The final report will describe these changes.

enrollment into the pilot and then refer individuals to providers for 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 successfully work together in the communities, often for the first time, and to share their resources and experiences. Most staff in these pilots suggested that the partnerships will be maintained and will continue to grow long after the pilots end. Washington pilot staff also found that engaging a wide array of partners and providers early in the planning process and distributing the pilot design and development work across the partners and providers 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 met the needs of the intended population.

At the same time, partnering came with 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 lack of clear communication between organizations and differing organizational missions or cultures. In some cases, the use of verbal rather than written communication led to inconsistent messaging to staff and providers. Communication generally improved after grantees began holding regular meetings with partners and providers and documenting important changes in policies or procedures in writing. In addition to communication, teaming with organizations that had not previously worked together required extensive coordination. Often, organizations had different approaches to employment and training. Some staff struggled to align each organization's mission for the pilot, which made it difficult for organizations to coordinate and standardize their policies and processes. To address these types of challenges, two pilots—Kansas and Kentucky—found it helpful to hold collective impact meetings in which all stakeholders periodically came together to discuss how to implement and improve the pilot. These meetings helped ensure everyone was invested in the pilot and working together toward a common goal.

2. **Developing and launching services that did not previously exist was particularly challenging, even when partnering with established providers.** Although many of the pilots were expanding an existing set of services or adding services that already were being provided to other groups, a few pilots created entirely new services or provided services in areas where SNAP E&T services had not previously been available. These more extensive development processes were sometimes challenging and resulted in slower than planned implementation. For example, both California and Mississippi developed new subsidized employment opportunities, but both pilots struggled to launch the efforts and move individuals into the opportunities. They faced challenges in finding employers who were both a good fit for the individuals in the pilot and willing to hire individuals. Even when the pilot did identify employers, the processes for moving individuals into employment opportunities could be slow due to requirements the individual had to meet to become ready for work-based learning or because the process of getting matched to a job could take a long time. 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, the 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 accessing services.

In Kentucky's pilot areas, there were no existing SNAP E&T services. Although the grantee heavily leveraged employment and training providers already working in these areas, it still faced challenges. The goals and missions of the various partner and provider organizations sometimes clashed, which made it difficult to weave existing services into a package of services that best fit the needs of those targeted for the pilot. For example, the Kentucky pilot was focused on providing occupation skills training and work-based learning opportunities, and then helping individuals transition into employment. However, each provider was focused on a slightly different goal based on their own mission, which created challenges early in the planning and implementation periods. The workforce agencies often aimed to get people into employment quickly while community colleges encouraged individuals to remain in classes long term (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.

3. **Take-up and completion of education, occupational skills training, and work-based learning activities were often lower than anticipated.** Several factors contributed to lower-than-expected take-up rates, including individuals' lack of interest in the offered services or willingness to enter lengthy trainings, barriers to participating in these activities, and implementation challenges for certain activities. Both staff and individuals participating in the pilot noted that take-up of occupational skills training activities may have been limited because individuals were more interested in finding a job than participating in an activity and felt they could not be out of the workforce while completing an education or occupational skills training program. For example, in Kansas and Illinois, fewer than expected individuals participated in occupational skills training, but many more than anticipated participated in job readiness skills training because individuals were interested in moving into the workforce quickly. In Delaware and Virginia, 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 and they were not of interest to many individuals in the pilot; eventually, the pilot expanded its offerings to better align with individuals' needs and interests. In Mississippi, Vermont, Virginia, and Washington, individuals were reluctant to participate in basic education or soft-skills trainings because it delayed participating in other activities (such as occupational skills training or work-based learning) or finding employment.

   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. Other barriers 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 referrals or openings to serve those in need. In Washington, individuals needed to reduce their barriers to employment before moving to activities, which sometimes took several months of dealing with pervasive issues like unstable housing or substance use disorder. In Illinois, staff and individuals in the pilot discussed that

transportation issues could interfere with participation if individuals had to travel a long distance to get to a service provider, and some had to travel to multiple locations to receive training, supports, and case management.

Some pilots had challenges in implementing certain activities, which also affected take-up. In California, the launch of the subsidized employment activity faced significant complications, and only a few individuals were able to start a subsidized job by the end of the second year of the pilot. Delaware also struggled to fully implement two of its occupational skills training programs, and far fewer individuals than anticipated started or completed the programs by the end of the second year of the pilot.

4. **The service models also affected rates of take-up and completion of services**. After implementing the planned models, several of the pilots realized the model was not working as planned and was affecting how individuals engaged in services. Reasons for this varied across the pilots. As described below, in some pilots, the staff initially did not fully understand the characteristics or interests of the populations the pilot served; in others, the model had multiple "hand-off" points or upfront requirements before individuals could enter employment, education, and training activities; and, in some, the model did not account for the flow of individuals into the pilot versus the timing of activities, which led to waiting periods before education or training activities started. As a result, individuals sometimes took up services at different rates than expected, did not progress through the service model as originally designed, or left the pilot before completing services.

   A few pilots, including those in Delaware and Virginia, found that the target population's anticipated needs and interests did not always match the actual needs and interests of the individuals who enrolled in the pilot. Because of this, take-up rates of certain activities did not always align with expectations. In some cases, pilots had to reallocate staffing and funds to activities in which individuals were more interested. For example, Virginia had assumed that most individuals would start in the basic education track. However, after the start of the pilot, pilot management realized that a significant share of individuals eligible for the basic education track were instead opting to participate in the occupational skills training track. In Delaware, where all three occupational skills training programs had lower take-up than expected, pilot staff and individuals participating in the pilot noted that all three of the targeted occupations—construction, culinary, and manufacturing—were viewed as male-dominated fields that many female treatment group members were not interested in pursuing.

   Some of the service models also faced structural challenges that increased opportunities for exits or limited take-up of substantive services. This often was 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 service provider organizations. 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 multi-week, 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. Staff reported that some individuals indicated that they needed to work and could not afford to attend a full-day class for several weeks. This sometimes caused individuals to leave the pilot before completing services or to find a job on their own and stop coming to the classes. In Washington, in particular, the completion rate for the soft-skills classes was much lower than expected, and thus few individuals moved on to education, occupational skills training, and work-based learning opportunities.

Several pilots also faced challenges with coordinating the flow of individuals into the pilot with the start dates of activities, particularly occupational skills training classes. These training 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 to start 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. Because of this, individuals referred to training just after classes began often had to wait until the start of the next scheduled class, which could 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 because they 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 in the class because they found employment in the meantime or chose to participate in other activities.

5. **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 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 (during focus groups) frequently discussed the importance of the support services in ensuring individuals could mitigate barriers to participation. In Kentucky, pilot staff and 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.

   Some pilot staff underestimated the level of supports needed to mitigate the barriers 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, particularly around

transportation. For example, some community colleges in Mississippi offered free shuttle services to transport individuals in the pilot from their homes to the colleges for services.

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, which was most prevalent in rural areas. Also, many of the pilots did not provide assistance for housing or provided assistance that often was not able to remediate the housing issues. Availability of shelters or transitional housing was limited in many areas, which further compounded the problem.

IV. PILOT SERVICES RECEIVED BY TREATMENT GROUP MEMBERS

This chapter summarizes cross-site participation analysis findings on the services treatment group members received through the pilot. Whereas Chapter II described the services and activities the pilots planned to offer, this chapter shows what services and activities individuals actually received.

The chapter begins with a summary of the treatment group's overall engagement in services, followed by descriptions of the specific activities individuals started and completed; the level and intensity of case management services received; the support services individuals received; and exit rates and timing of exits. All findings are based on administrative service use data recorded by pilot service providers. For each individual enrolled through December 2017, the findings reflect service receipt during the 12-month period following random assignment.

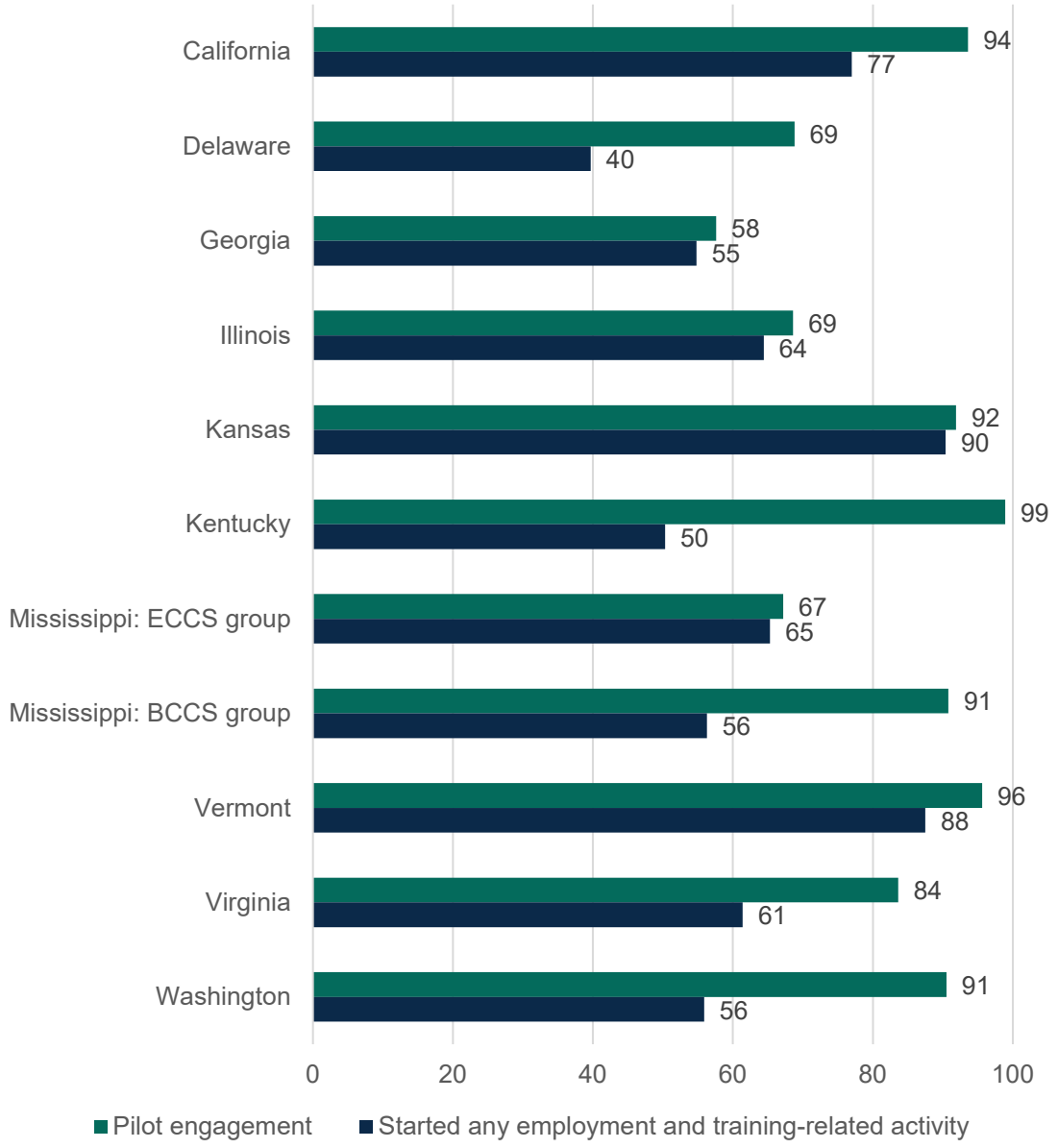
A. Overall engagement in pilot services

In all pilots except Georgia, 67 percent or more of the individuals assigned to the treatment group started pilot intake, assessments, or an employment or training-related activity after random assignment (Exhibit IV.1). In most pilots, initial engagement rates among treatment group members were higher than 80 percent, but Delaware (69 percent), Georgia (58 percent), Illinois (69 percent), and the ECCS group in Mississippi (67 percent) had lower rates of engagement. The lower rates may be due, in part, to the pilot models—in these sites, individuals were enrolled at a different location from where they subsequently received assessments and services or were often enrolled and then scheduled for an appointment to come back for their assessment.

Treatment group members who did engage in pilot services generally were active for an average of 125 to 260 days, depending on the pilot (not shown); however, there was a wide range from about 16 days in Georgia to almost a full year (324 days) in California. Because California's pilot services were designed to last for 18 months, this duration is not surprising. In contrast, individuals who engaged in Georgia had the lowest average length of pilot engagement; 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 they completed intake and assessments were lower (Exhibit IV.1). In most pilots (7 of 10), 65 percent or less of treatment group members started an activity. However, this statistic varied widely across the pilots, ranging from a low of 40 percent in Delaware to a high of 90 percent in Kansas.

Exhibit IV.1. Percentage of individuals who engaged in each pilot and started employment and 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. Estimates cover the 12 months following random assignment.

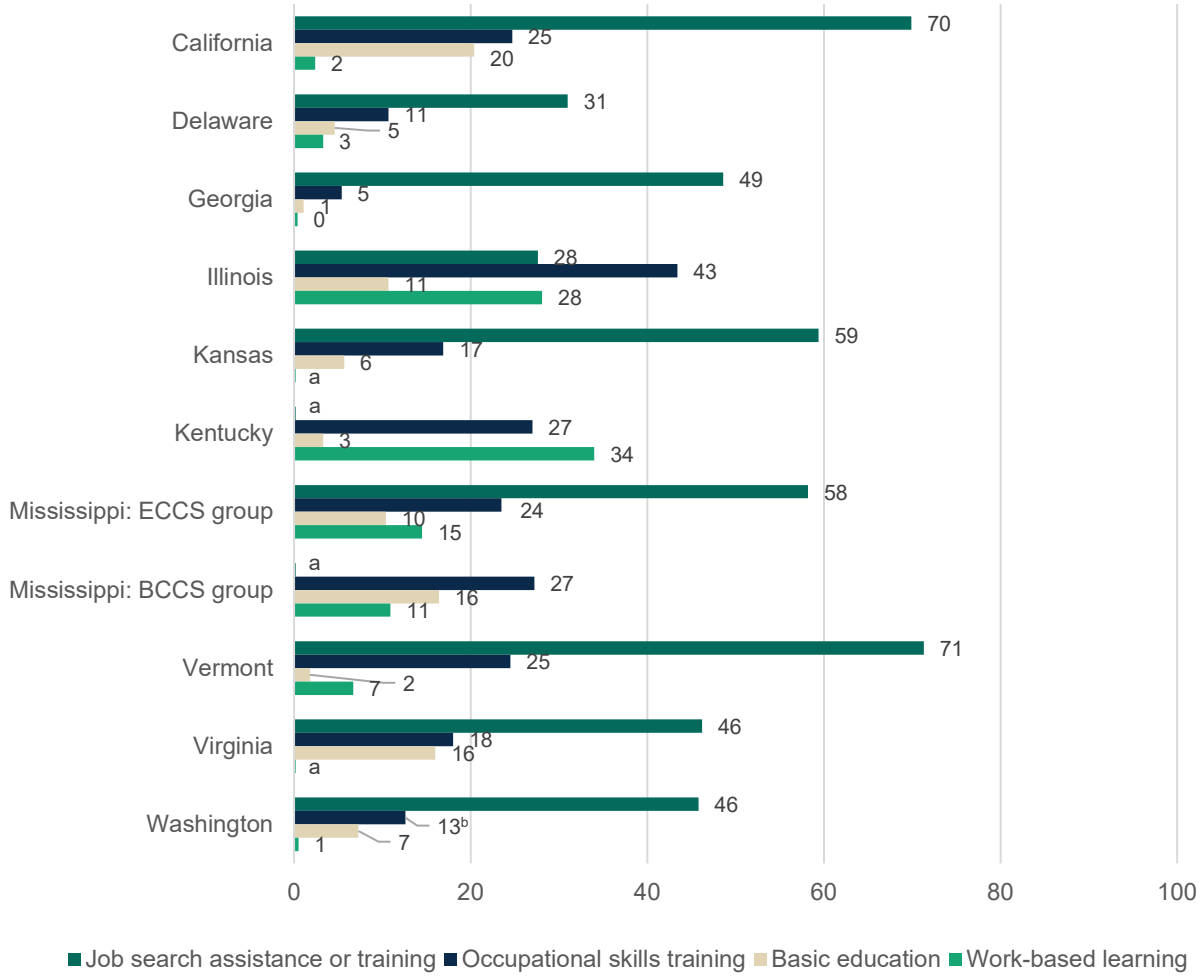
1. Participation in employment and training-related activities

Pilots offered an array of employment and training-related activities, but most pilots included four key types of activities—job search assistance or training, occupational skills training, basic education, and work-based learning. Exhibit IV.2 presents the percentage of treatment group members who started each one of these four types of activities. In the majority of pilots, the activity in which most treatment group members participated was job search assistance or training (28 to 71 percent).[17] Generally, smaller percentages of treatment group members participated in the other three types of activities. About 10 to 30 percent of individuals in each pilot started an occupational skills training activity; however, the percentages were lower in Georgia (5 percent) and higher in Illinois (43 percent). Fewer individuals started basic education—10 percent or fewer started basic education in seven of the pilots, but rates were much higher in California (20 percent), Mississippi BCCS group (16 percent), and Virginia (16 percent), which were pilots that focused on basic education. (California added in-house GED preparation classes for the treatment group, Virginia designated one of three tracks for basic education, and Mississippi's adult basic education services were co-located at the community colleges where all other services were provided.) Eight pilots offered some type of work-based learning, such as subsidized employment, work experience, internships, or work study, but, in most pilots, fewer than 15 percent of individuals participated in this activity; in some pilots, participation was 1 percent or less (Georgia and Washington). The exceptions were in Kentucky and Illinois, where around 30 percent of treatment group members participated in work-based learning.

Completion rates among individuals who started an activity were generally higher than 50 percent for all activities except basic education (Exhibit IV.3). These rates provide a snapshot of completion at the end of the 12-month follow-up period; however, some individuals who started these activities may still have been participating and did not yet complete them by the end of the 12 months. Completion rates for individuals who started job search assistance or training were 60 percent or higher in each pilot except for Vermont where it was much lower (38 percent). These activities often could be completed quickly, so the higher completion rates could be related to the lower time commitment required. Completion rates were somewhat lower for occupational skills training: 50 percent or more of individuals who started training completed it in 7 of the 10 pilots. Completion rates ranged from 35 percent in Kentucky to 89 percent in Virginia, but most pilots fell within the 50 to 65 percent range. Individuals tended to complete basic education at lower rates than the other activities: in four of the pilots, 38 percent or more of individuals completed basic education classes, while completion rates were only 10 to 34 percent in the others. California had the largest percentage of individuals who started basic education, but it had the lowest completion rate at 10 percent. In contrast, Kansas had fewer individuals starting basic education (6 percent), but most of them completed it (85 percent). Finally, in most pilots, 50 to 60 percent of individuals who started a work-based learning activity completed it, ranging from 38 percent completion in Illinois to 89 percent completion in Delaware.

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

Exhibit IV.2. Percentage of treatment group members who started activities, by pilot



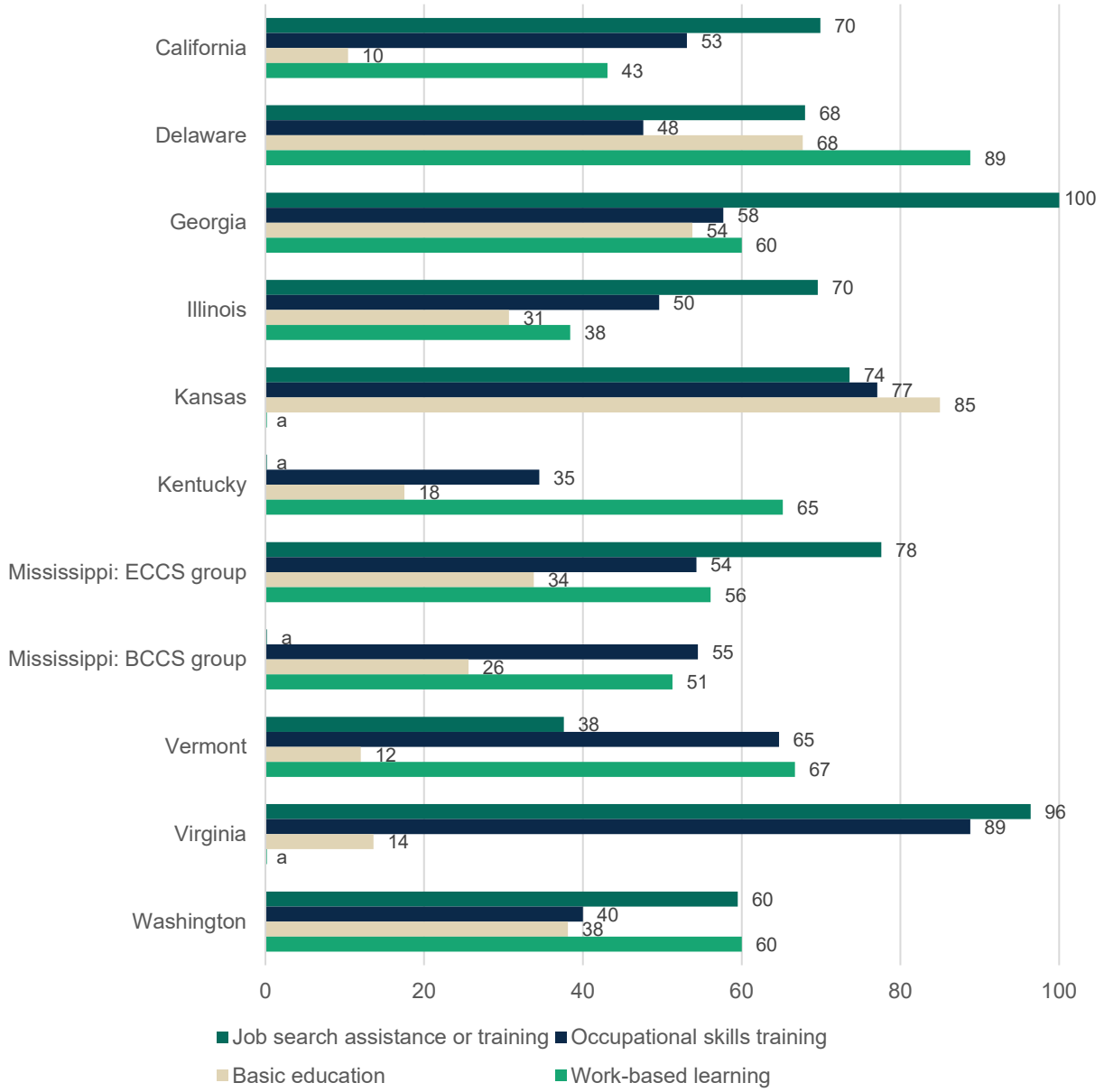
Source: SNAP employment and training evaluation administrative service use data.

Note: Job search assistance or training includes the structured upfront soft skills or life skills training courses offered in Mississippi and Washington. If a pilot offered both job search assistance and job search training, the value of the activity with the highest participation is included; the percentage of individuals in both activities is not shown. Estimates cover the 12 months following random assignment.

[a]Indicates the activity was not offered.

[b]Due to the way in which data were provided, occupational skills training in Washington also includes post-secondary education. These values could not be separated; however, most Washington treatment group members participated in occupational skills training.

Exhibit IV.3. Completion rates for activities, among individuals who started an activity, by pilot



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

Note: Estimates cover the 12 months following random assignment.

[a]Indicates the activity was not offered.

2. Credentials and certifications

Few treatment group members obtained an occupational skills training credential or certification (not shown). In each of the nine pilots that provided administrative service use data on credentials and certifications,[18] fewer than 20 percent of treatment group members in each pilot

[18] Kansas could not provide data on receipt of credentials or certifications.

received a credential, ranging from 1 percent in Washington to 19 percent in Illinois. In six pilots, 7 percent or fewer treatment group members earned a credential or certification.

Among the pilots that reported the types of credentials or certifications earned most frequently, there was a mix of occupations, but training in the medical field (including certified nursing assistantships, phlebotomy, and first aid) appeared in the top five types of credentials or certifications earned across the pilots. Other top five types of credentials individuals earned were for culinary arts, commercial driver's licenses, construction, and welding or ironworking.

B. Receipt of case management

In each of the nine pilots with available case management data, the majority (64 to 100 percent) of treatment group members had at least some contact with a case manager (Exhibit IV.4).[19] 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 is largely due to most individuals engaging with case managers immediately or shortly after random assignment. The average number of contacts per person is a more indicative measure of the intensity (or frequency) of case management across the pilots. In the eight pilots with case management contact data (all but Kansas and Vermont), intensity varied widely; among individuals who had some contact with case managers, the average number of contacts per person ranged from 5 for the ECCS group in Mississippi to 34 in Delaware (case managers in Delaware were asked to contact individuals at least once a week while engaged in the pilot). Five pilots had an average of 10 or more total contacts.

Because individuals were engaged in the pilots for different amounts of time, the overall average number of contacts with case managers, although useful, does not fully measure the intensity of contacts—the intensity depends on how long individuals were engaged in the pilot. Thus, the average number of contacts per individual per month that they were engaged in the pilot is perhaps the most useful measure of intensity. Among individuals who had some contact with case managers, the average number of contacts per month ranged from less than one in Kentucky to 8 in Delaware (Exhibit IV.4). Comparing the two intensity measures (total number of contacts and contacts per month) for Delaware and California shows how informative the measure of contacts per month can be. Delaware had the highest average for both total contacts and number of contacts per month (34 and 8, respectively). In contrast, California had the second highest average for total contacts (28) but had a substantially lower average than Delaware for the number of contacts per month (3). This shows that while Delaware and California both had similar numbers of total contacts, those in Delaware had more contact with a case manager during each month they spent in the pilot than did those in California, due to the differing lengths of time individuals spent in each pilot.

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

Exhibit IV.4. Description of contacts with case managers, among treatment group members, by pilot

Contact	California	Delaware	Georgia	Illinois	Kentucky	Mississippi: ECCS group	Mississippi: BCCS group	Vermont	Virginia	Washington
Any contact (%)	96.4	99.9	92.5	98.5	95.5	64.2	75.4	85.6	94.0	93.5
Average number of contacts per person	26.7	34.0	14.0	12.4	7.5	3.4	4.1	NA	8.3	18.3[a]
Average number of contacts per person, among those with a contact	27.7	34.0	15.1	12.6	7.9	5.3	5.5	NA	8.8	19.3[a]
Average number of contacts per person per month, among those with contact	2.8	7.5	1.3	1.0	0.1	1.5	1.6	NA	0.7	3.6[a]
Among contacts, type of contact (%)										
In person	28.8	17.6	17.7	35.7	99.9	55.1	63.3	NA	28.0	38.8[b]
Telephone	39.2	43.8	38.4	25.7	0.1	39.4	32.1	NA	42.9	49.1[b]
Electronic (email, text, social media)	30.8	25.6	18.8	11.6	0.0	3.4	2.8	NA	12.3	12.1[b]
Mail	1.2	13.0	23.9	26.6	NA	NA	NA	NA	16.7	NA
Sample Size	1,797	2,672	200[c]	200[c]	1,259	737	736	1,378	200[c]	2,186

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. Estimates cover the 12 months following random assignment. Data in this table represent all contacts that case managers documented between themselves and individuals in the pilot. In some cases, these could include contacts that were not direct communication (such as mailing documents to an individual), but even these were likely needed services that helped the individual. We did exclude contacts such as leaving a phone message or sending mass mailings, where applicable. Kansas is not included in the table because it could not provide data on case management.

[a]The number includes only those individuals randomly assigned on or after September 1, 2016 because the pilot did not capture these data before that date.

[b]The percentage includes only data from August 2017 through September 2018 because Washington did not capture these data before that date. These data should be viewed as showing only the general distribution of contacts by type, as the exact numbers may be affected by the truncated data collection period. Although the distribution is reasonable based on qualitative reporting from provider staff, the exact numbers of contacts by type are higher than the average number of contacts per month based on data from a longer period. It is possible individuals had more contact in the later months of the pilot and the types of contacts may have changed over time.

[C]The pilot tracked the frequency and type of contacts only through narrative case notes, therefore, the evaluation team members reviewed and coded electronic case notes for a randomly selected subsample of treatment group members and used these data to analyze the frequency and type of contacts.

In most pilots, case managers used multiple contact methods, but contact by telephone was the most frequent (Exhibit IV.4). In most of the pilots that provided detailed case management data, close to 40 percent or more of contacts took place by telephone; in-person contacts were less common, ranging from 18 percent in Delaware and Georgia to 39 percent in Washington. In Kentucky, virtually all contacts were in person—most individuals received transportation assistance, which was provided monthly through a check that individuals collected in person at which time they generally checked in with their case manager—and over half of all contacts were in person in Mississippi—case managers were at the community college where individuals also were on site each week to participate in activities.

C. Receipt of support services

Existing SNAP E&T programs offer support services (transportation and child care assistance are Federally mandated) to reduce some types of barriers that might compromise SNAP E&T participants' ability to take full advantage of E&T services or find employment. However, the pilots generally offered more generous and a wider variety of supports as a possible means of increasing participation in activities and improving outcomes. In all of the pilots providing data,[20] generally 50 to 70 percent of the treatment group received some type of support service (Exhibit IV.5).[21] However, as with other measures of service receipt, there was substantial variation across pilots in rates of receiving any support services, ranging from 25 percent in Georgia to 87 percent in Mississippi's ECCS group.[22]

Transportation assistance was the most common support provided. In most of the pilots, almost all of the individuals who received a support received transportation assistance; percentages were lower in California and Vermont where the pilot did not provide a standard amount of transportation assistance or on a specific schedule (such as weekly or monthly)—all supports were customized to need. In all but two of the pilots, very few individuals (zero in most cases) received child care assistance. This may be related to need: many pilots served ABAWDs (two exclusively) who, by definition, did not have children, and SNAP participants with children younger than 6 are exempt from work registration. Among the pilots, Kentucky provided child care assistance to the largest percentages of the treatment group (14 percent).[23] Pilots also offered a range of other types of supports including covering expenses related to occupational skills training, clothing for interviews or employment, housing assistance, medical assistance

[20] Kansas could not provide data on types or amounts of support services; the pilot only reported on the overall number of individuals who received a support service.

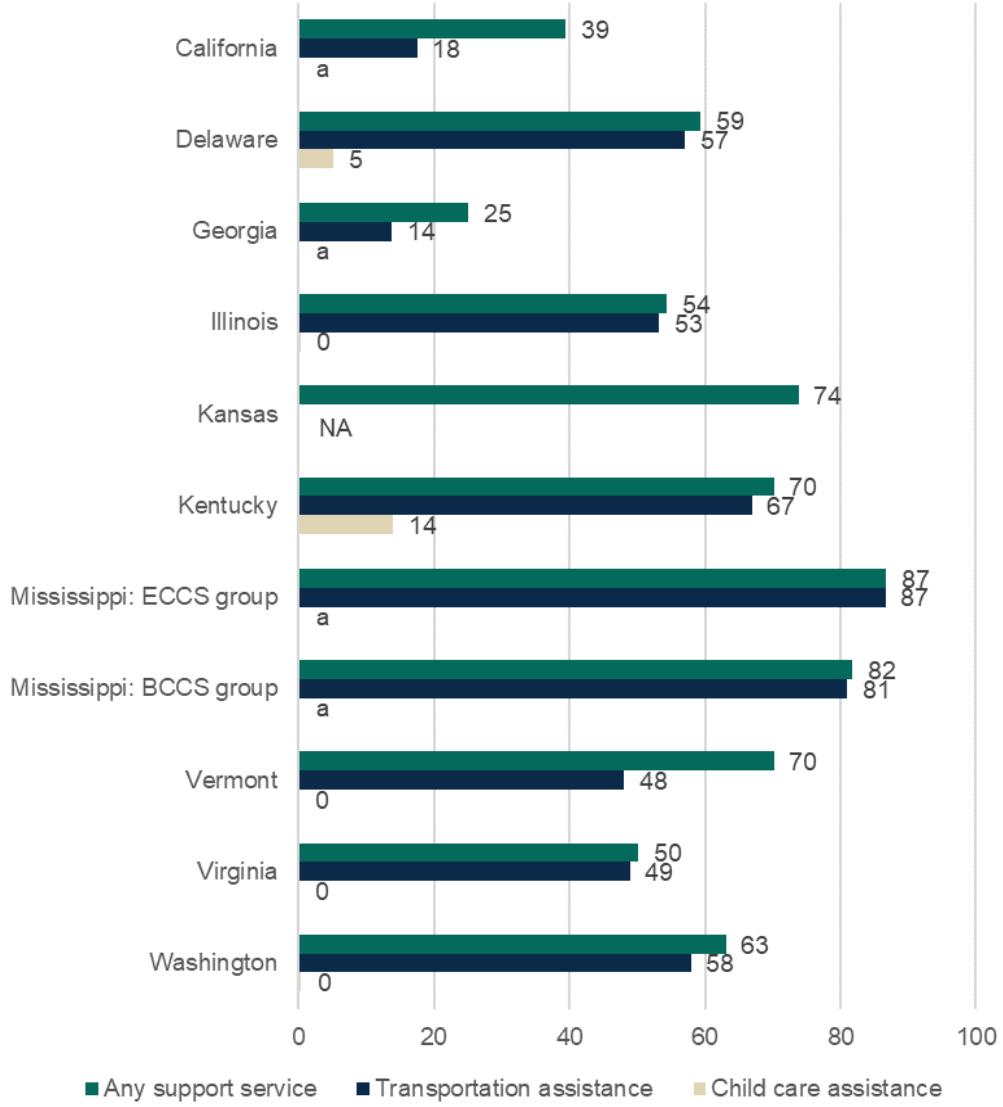
[21] Only about 25 percent of individuals in Georgia received supports according to the available data; however, this is likely an underestimate of the proportion of individuals who received support services because both the provider and the SNAP agency provided support services to treatment group members, but only data from the provider were available.

[22] Note that a higher percentage of Mississippi's treatment group members received support services than had a contact with a case manager or started services because most treatment group members received a $50 transportation support at enrollment, before their first meeting with a case manager.

[23] Kentucky found that many SNAP participants with young children who were not work registrants frequently wanted to enroll in the pilot. Thus, for several months the State opened the pilot to non-work registrants. Many of those individuals had young children, which likely drove up the need for child care assistance.

(such as dentures or eyeglasses), and work supports (such as tools or equipment, scrubs, or work shoes).

Exhibit IV.5. Percentage of individuals who received any support service and received each type of available support service, by pilot



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

Note: Estimates cover the 12 months following random assignment.

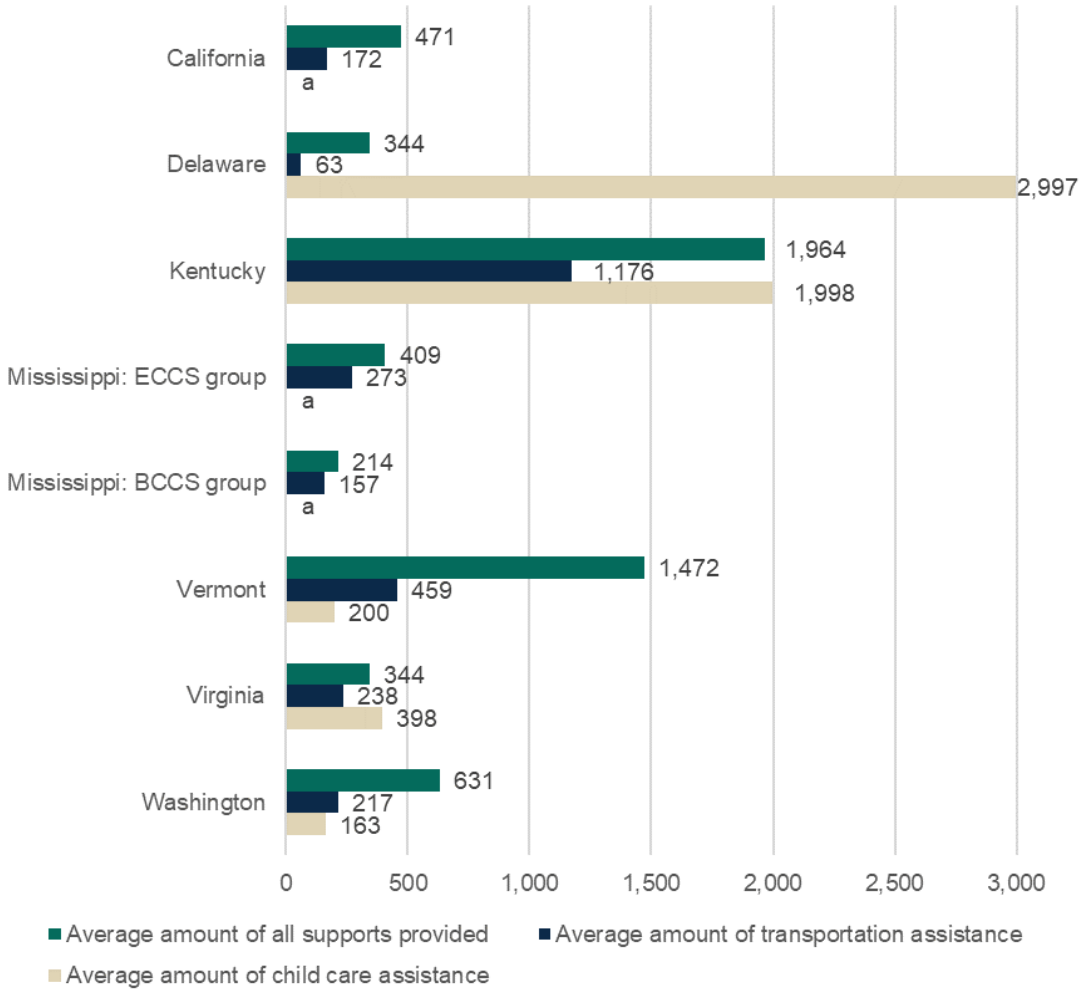
[a]Indicates the pilot did not offer direct payments for the type of support service.

NA indicates the pilot could not provide data activity was not offered.

To measure the level of support services individuals received, Exhibit IV.6 presents the average dollar value of support services treatment group members received in total for all supports and for transportation and child care assistance specifically. Among individuals who received some type of support, the average value of all support services ranged from $214 in Mississippi's BCCS group to $1,964 in Kentucky. With the exception of Kentucky and Vermont, most pilots provided an average of $340 to $630 in support services. Often, child care assistance was the

costliest support service provided because child care in most areas is expensive and is a per child benefit that could be needed every day, whereas other support services are for one person and generally needed only once or less frequently. For the pilots that offered child care assistance, the average dollar value of the supports ranged from $163 in Washington to almost $2,000 in Kentucky and $3,000 in Delaware. Transportation assistance was generally provided every month an individual was engaged in the pilot, and some pilots offered support for car repairs, which could cost more than $1,000. Among treatment group members who received transportation assistance, the average total dollar value of supports the pilots provided per person ranged from $63 in Delaware to $1,176 in Kentucky but generally fell in the $150 to $460 range for most pilots.

Exhibit IV.6. Average amount of all support services and each type of available support service pilots provided per person, among those who received supports (in dollars), by pilot



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 are not included in the exhibit. Estimates cover the 12 months following random assignment.

[a]Indicates the pilot did not offer direct payments for the type of support service.

D. Pilot exits

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 three primary categories: an individual successfully completed assigned services or found employment and left the pilot; an individual left before completing assigned services, which could include individuals notifying the staff they were leaving or the individual no longer showing up and staff could not contact them; and the individual became ineligible for SNAP or the pilot, which could include someone being sanctioned and losing SNAP or not completing the recertification process each year.

In seven pilots, 70 percent or more of individuals exited the pilot within their first year (Exhibit IV.7). Three pilots—Delaware, Georgia, and Mississippi—had exit rates of 90 percent or more, with Delaware having the highest rate, at 95 percent. California and Kentucky had much lower exit rates, at 27 percent and 52 percent, respectively. Individuals most often left the pilot before completing services, or they became ineligible for the pilot due to losing SNAP benefits, receiving TANF, or not complying with pilot rules and being terminated. Few individuals exited the pilot due to completing all the pilot activities or finding employment (30 percent or fewer across pilots).

Exhibit IV.7. Percentage of individuals who exited and reasons for exit, by pilot

	California	Delaware	Georgia	Illinois	Kansas	Kentucky	Mississippi: ECCS group	Mississippi: BCCS group	Vermont	Virginia	Washington
Exited pilot for any reason	26.8	94.9	90.1	73.5	78.3	51.7	92.1	90.1	63.8	69.5	82.5
Reason for exit, among those who exited											
Completed or left for employment	0.2	30.3	22.1	27.3	25.5	9.5	NA	NA	26.3	12.8	21.8
Left before completing[a]	64.9	62.4	49.4	46.4	10.5	90.4	NA	NA	37.5	61.8	75.4
Became ineligible for SNAP or pilot	34.8	3.1	27.0	26.3	56.6	--[b]	NA	NA	36.2	1.6	2.8
Other[c]	--[b]	4.3	1.5	0.0	7.2	--[b]	NA	NA	--[b]	23.8	--[b]

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

Note: NA indicates the pilot was not able to provide the data. Estimates cover the 12 months following random assignment.

[a]Includes individuals who never attended provider orientations in Georgia (33.6 percent), Illinois (35.2 percent), and Virginia (16.3 percent).

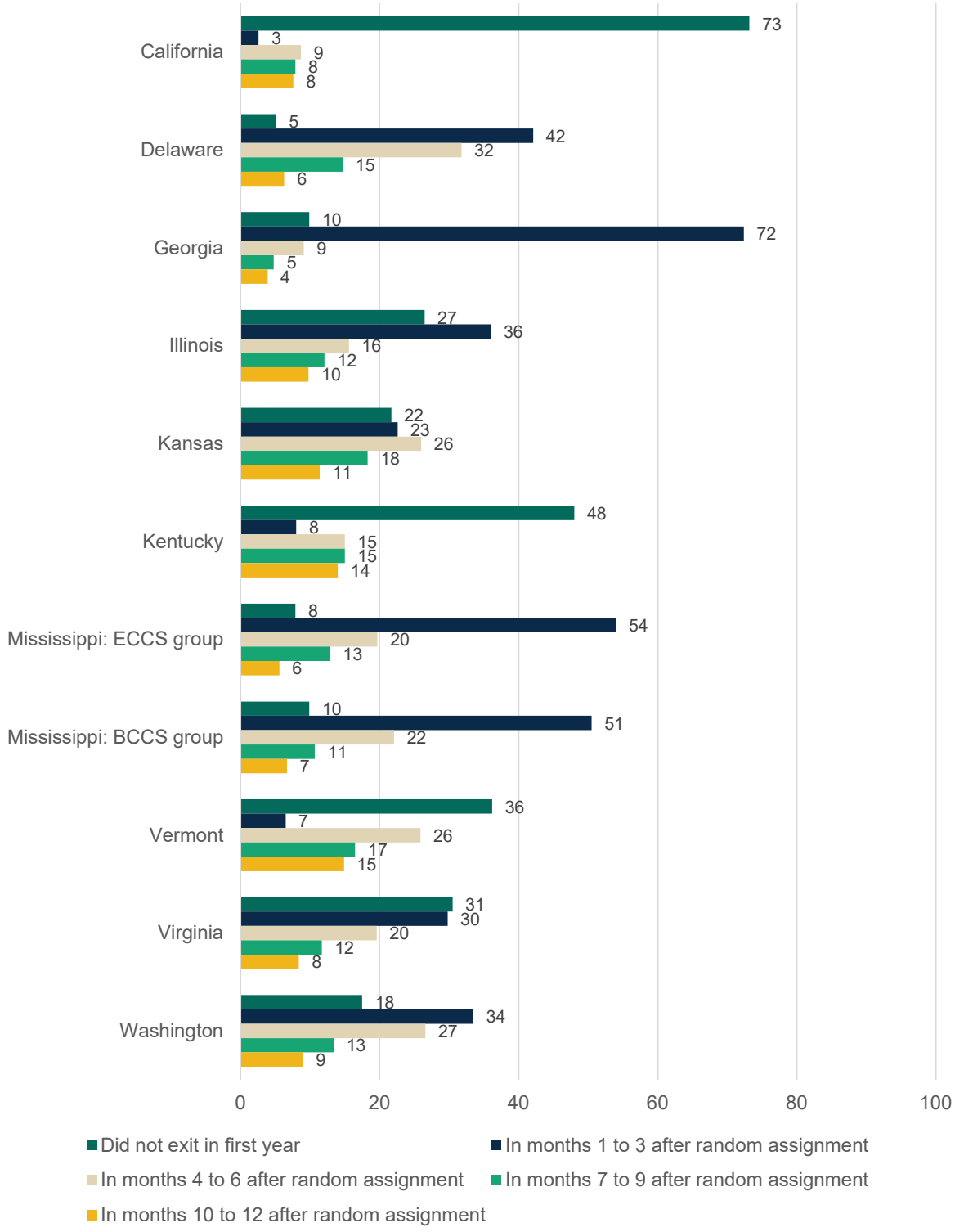
[b]The pilot did not track this exit reason.

[c]Other reasons for exit include those determined by the pilot staff as not fitting into one of the defined reasons for exit or those cases that did not have a reason coded.

In six pilots, 30 percent or more of treatment group members exited the pilot within the first three months after random assignment (Exhibit IV.8). Georgia had the highest rate of exit during this period (72 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 23 percent in Kansas, and individuals generally remained in these pilots longer. In fact, at the end of the 12-month evaluation period, 73 percent of individuals in California were still participating in services, likely due to the model serving individuals for 18 months. In Kentucky and Vermont, more than 35 percent of individuals were still in the pilot at month 12. In the other six pilots, most individuals had exited at some point before the seventh month after random assignment.

The pilot exit findings suggest that, in the majority of pilots, many treatment group members left the pilot in a short period of time, which limited their access to services and activities. However, treatment group members can leave the pilot for a variety of reasons. Some individuals may have completed services and found employment before exiting. Others may have left the pilot before completing services because they found employment. Some exits may indicate a loss of SNAP eligibility or the effects of being sanctioned for failing to meet state-specific program work requirements. Whether exits affect pilot impacts depends not on the experiences of the treatment group alone, but on the contrast between treatment and control groups in the receipt of services and length of receipt (presented in Chapter V).

Exhibit IV.8. Percentage of individuals who exited over time, by pilot



Source: SNAP employment and training evaluation administrative service use data.
Note: Estimates cover the 12 months following random assignment.

V. DIFFERENCES IN SERVICE RECEIPT FOR THE TREATMENT AND CONTROL GROUPS ACROSS PILOTS

This chapter describes how service use differed between treatment and control group members across the pilots. Understanding differences between the treatment and control groups (research groups) provides important context for interpreting the range of impacts across pilots on employment, earnings, and receipt of public assistance. Without a meaningful difference in the type, incidence, or amount of services received by the research groups within a pilot, impacts on labor market and public assistance outcomes are unlikely to result.

Findings discussed in this chapter are based on responses to identical 12-month follow-up survey questions asked of treatment and control group members across the pilots. These data describe the employment, education, and training activities in which individuals participated during the year following random assignment, including type and duration, as well as case management and support services that individuals may have received. 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 GED courses, ESL classes, or college courses; occupational skills training programs that prepared individuals for specific occupations; general job skills training programs that help individuals learn widely-applicable job skills and ready them for work; and work-based learning activities, such as paid or unpaid internships and apprenticeships.

The survey data capture any type of activity or service received through the pilot, the existing SNAP E&T program, or community programs, such as ones funded by WIOA or provided by community colleges, nonprofits, or other organizations. The activities and services the control group received define the "counterfactual" for the evaluation, that is, the activities and services the treatment group would have received in the absence of the enhanced sets of activities and services offered under the pilots.

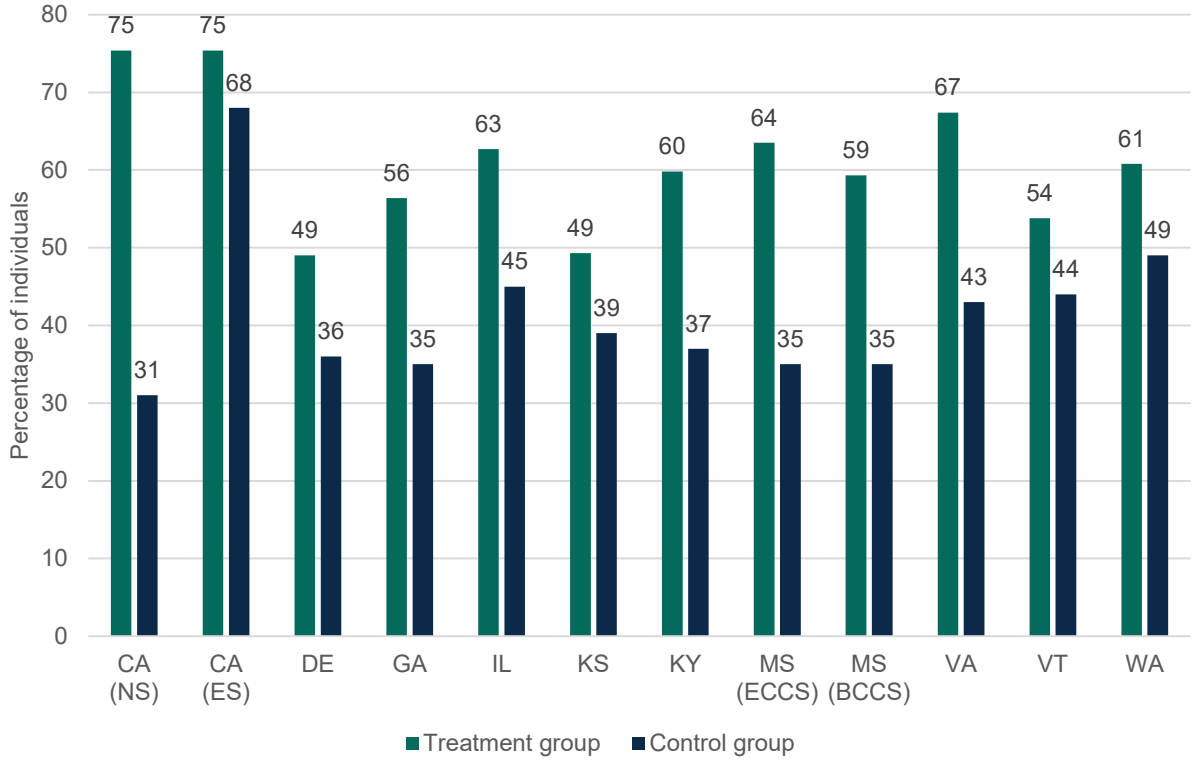
A. Differences in participation in any activity

The percentages of treatment and control group members that participated in any activity are presented in Exhibit V.1. In each pilot, many control group members who were not eligible for pilot services participated in activities through existing SNAP E&T services or community-offered services, ranging from 31 percent in the "no [SNAP E&T] service" (NS) control group in California to 49 percent in Washington and 68 percent in the "existing service" (ES) control group in California.[24] In most pilots, control group members were most likely to participate in

[24] The findings in this chapter show that in California the ES control group was much more likely to receive services and participate in activities than the NS control group. As a result, there was a smaller contrast in service participation between individuals in the treatment group and the ES control group, than between individuals in the treatment group and the NS control group. This was expected at this interim stage of follow-up, for two reasons.

job search training or assistance activities, but sizable percentages of control group members participated in education and training programs as well (Appendix Table C.1).

Exhibit V.1. Percentage of treatment and control group members who participated in any activity—job search assistance or job search training activities, or education or occupational skills training, by pilot



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

Notes: CA (NS) and CA (ES) refer to the comparison of the treatment group in California to the "no service" and "existing service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the comparison between the ECCS and BCCS treatment groups in Mississippi and the control group.

In all of the pilots, the treatment groups were more likely than the control groups to participate in some type of activity—job search assistance or job search training activities, or education or occupational skills training—within the 12-month follow-up period (Exhibit V.2). The differences between research groups were statistically significant in all pilots but the magnitude of the differences varied across them (Exhibit V.2). For example, in California, 75 percent of treatment group members participated in activities, compared with 31 percent of the NS control

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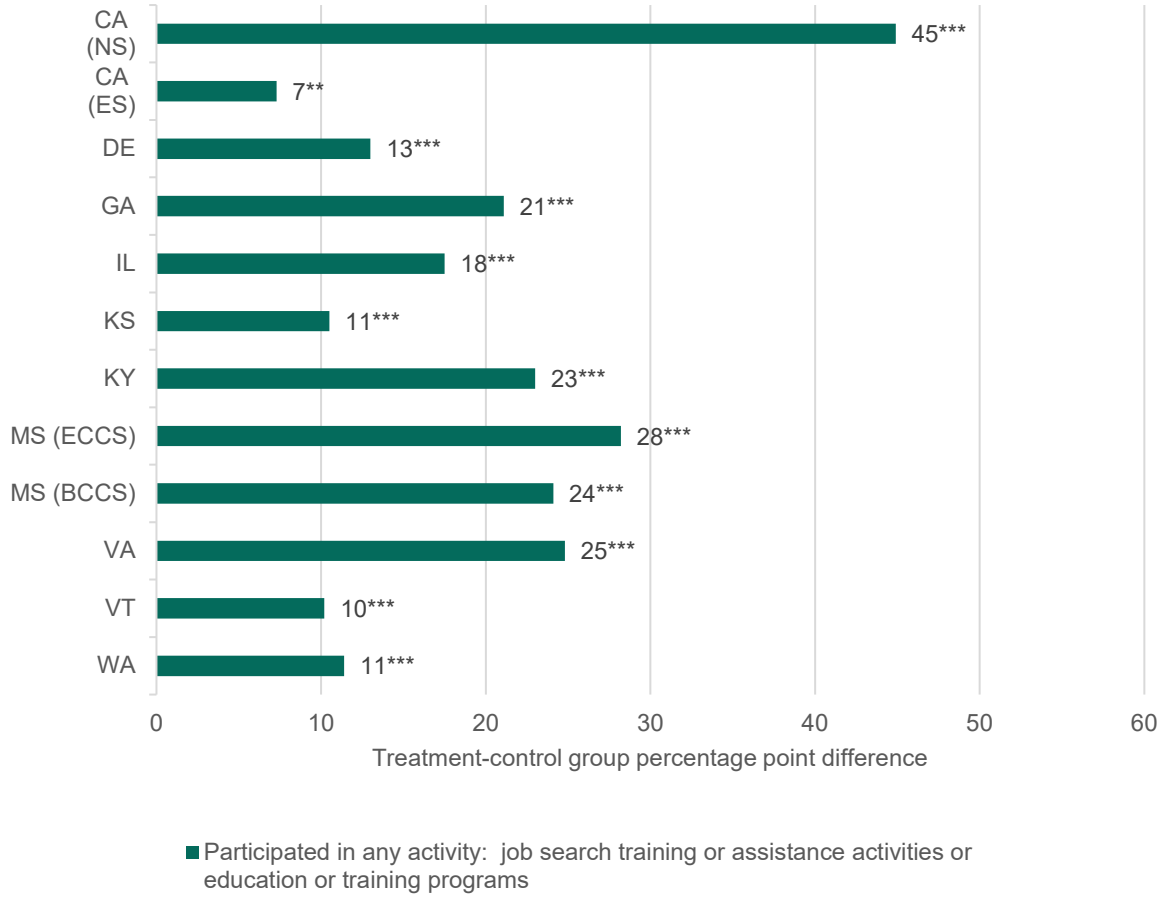
First, the treatment group and ES group were offered similar services, with the exceptions that the ES control group could not receive in-house GED preparation classes, subsidized employment, or incentives. Second, during the 12 months following random assignment, few treatment group members participated in subsidized employment, and incentives were earned, but no one received a payment. When longer follow-up is available, a greater contrast in service participation between individuals in the treatment group and the ES control group may emerge.

group, resulting in a 45 percentage point difference relative to the NS control group. In Vermont, this difference was 10 percentage points.

Exhibit V.2. Treatment–control group difference in participation in any activity during the 12 months after randomization, by pilot



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

Notes: Estimates measure the difference between participation in treatment services or community-offered services among treatment group members and participation in existing SNAP E&T services or community-offered services among control group members. CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" 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.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.
(CA (NS) $p < 0.01$; CA (ES) $p = 0.03$; DE $p < 0.01$; GA $p < 0.01$; IL $p < 0.01$; KS $p < 0.01$; KY $p < 0.01$; MS (ECCS) $p < 0.01$; MS (BCCS) $p < 0.01$; VA $p < 0.01$; VT $p < 0.01$; WA $p < 0.01$)

We find similar patterns of treatment–control group differences when examining participation in two types of activities: (1) job search assistance or job search training and (2) education and

occupational skills training (Appendix Table C.1). Overall, treatment group members were more likely than control group members to participate in both types of activities.

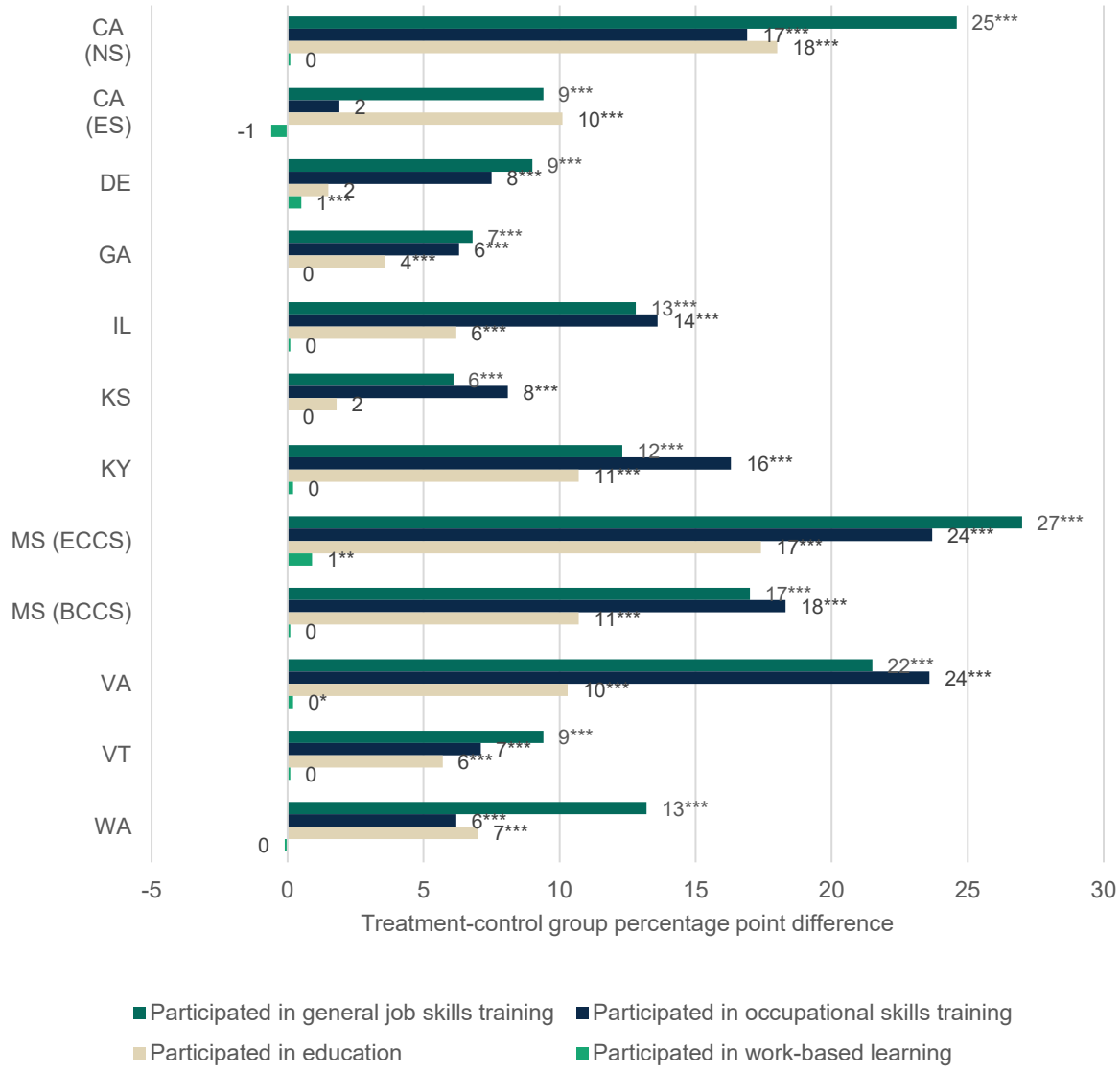
The variation in control group participation rates across pilots reflects differences in existing service availability and target populations (Appendix Table C.1). In several pilot sites, for example, existing SNAP E&T programs did not exist, so control group members received services solely through programs in their communities (the California NS control group and the control group in Kentucky). In other sites, comprehensive sets of existing SNAP E&T services were not available to control group members (Mississippi and Georgia). The finding that all pilots were able to increase treatment group members' participation in activities to levels higher than those of their respective control groups suggests that it is possible to improve engagement in these types of activities, regardless of the types of services and activities offered and the populations targeted.[25]

B. Differences in participation in education or occupational skills training activities

As discussed, individuals in the treatment group were more likely than those in the control group to start either an education or occupational skills training activity (Appendix Table C.1). Typically, the differences between research groups in participation in occupational skills training were larger than in education programs (Exhibit V.3). Across the pilots, statistically significant differences between research groups for participation in occupational skills training ranged from 6 to 24 percentage points, whereas differences in participation in education ranged from 4 to 18 points. Treatment–control group differences were largest for participation in general job skills training (ranging from 6 to 27 percentage points), which encompassed job readiness activities. 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 States (Appendix Table C.2).

[25] In Mississippi, at the same time the State was implementing the pilot, State staff were also significantly redesigning their existing SNAP E&T program. Both were launched around the same time and the existing E&T program became a mandatory program focused on job search. As a result, a comprehensive set of services was not available to control group members in Mississippi, and because the mandatory program was new, many individuals in the control group may not have understood the requirements and may have been sanctioned, thereby losing SNAP eligibility and access to SNAP E&T services. In Georgia, existing SNAP E&T services consisted almost solely of a mandatory, four-week independent job search activity.

Exhibit V.3. Treatment-control group differences in participation in specific types of activities, by pilot



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

Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" 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.

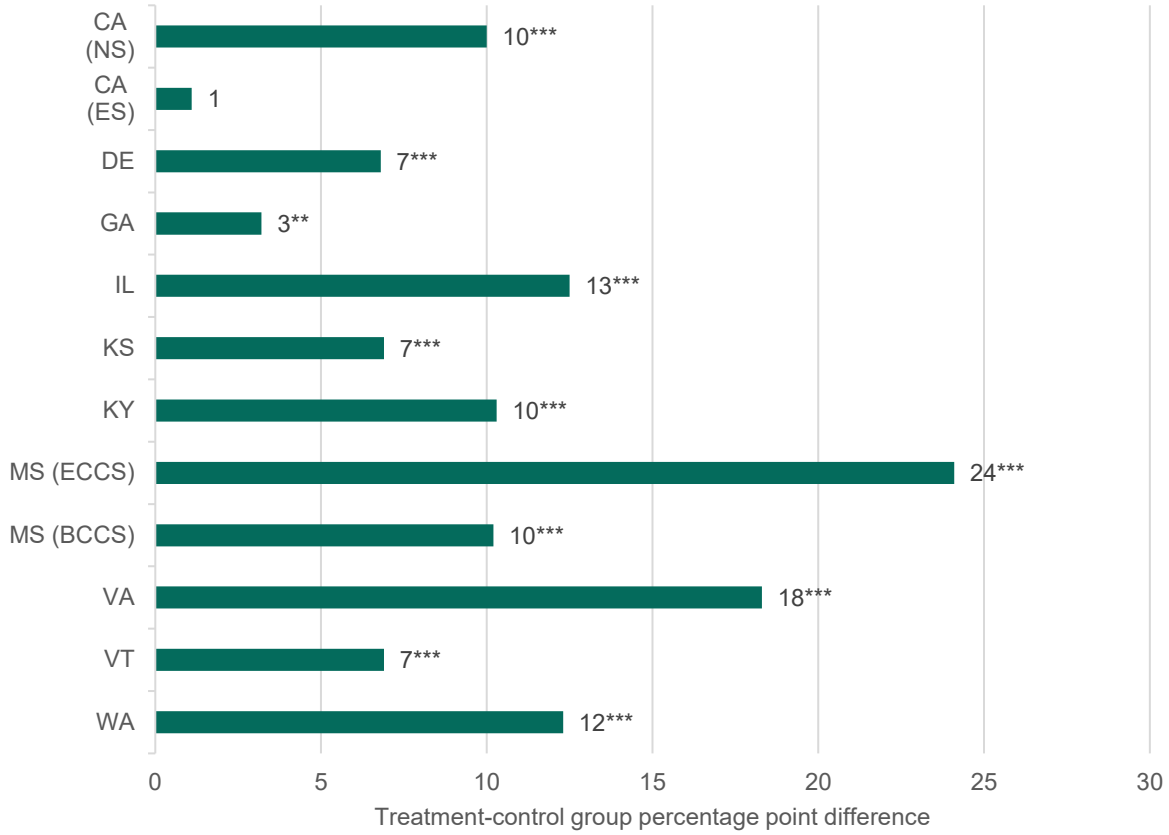
The treatment-control difference for work-based learning in Virginia is equal to 0.2. Estimates in decimal form are presented in Appendix Table C.2.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.
(General job skills training: CA (NS), CA (ES), DE, GA, IL, KS; KY, MS (ECCS), MS (BCCS), VA, VT, and WA $p < 0.01$
Occupational skills training: CA (NS), DE, GA, IL, KS, KY, MS (ECCS), MS (BCCS), VA, VT, and WA $p < 0.01$
Education: CA (NS), CA (ES), IL, KY, MS (ECCS), MS (BCCS), VA, VT, and WA $p < 0.01$; GA $p = 0.01$
Work-based learning: DE $p = 0.01$; MS (ECCS) $p = 0.03$; VA $p = 0.07$)

C. Differences between research groups in the completion of education and training programs and activities

In all pilots, the treatment group had higher completion rates for education and training activities than the control group (Exhibit V.4; Appendix table C.3). The magnitude of the statistically significant differences varied across pilots but was largest in Mississippi (24 percentage point difference for the ECCS group) and smallest in Georgia (3 percentage point difference). Large differences between research groups in the rates of completion of education and training activities generally reflected that individuals in the treatment groups were more likely than those in the control groups to start these activities (Appendix Table C.3).

Exhibit V.4. Treatment–control group differences in completion rates of education and training activities, by pilot



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

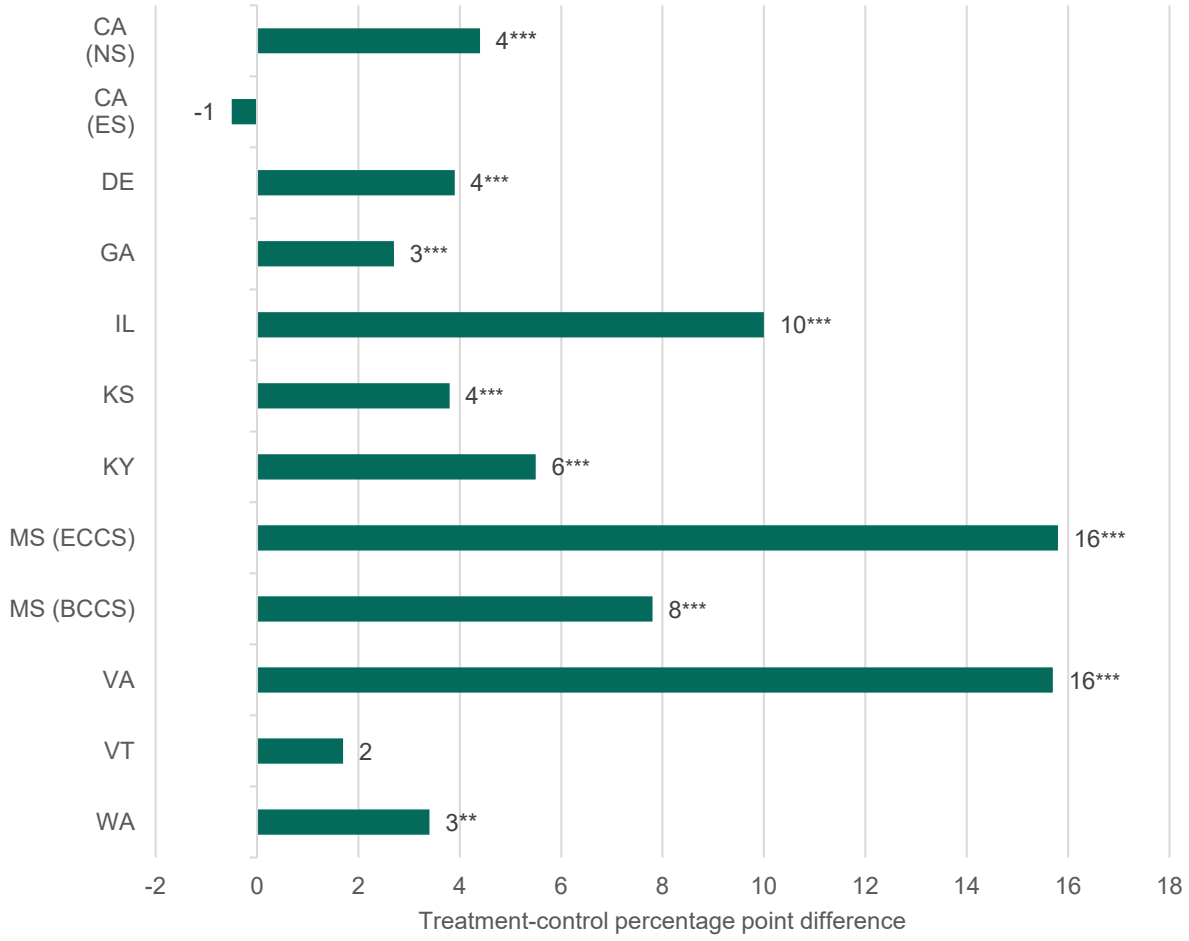
Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the differences between the ECCS and BCCS treatment groups in Mississippi and the control group.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(CA (NS) $p < 0.01$; DE $p < 0.01$; GA $p = 0.02$; IL $p < 0.01$; KS $p < 0.01$; KY $p < 0.01$; MS (ECCS) $p < 0.01$; MS (BCCS) $p < 0.01$; VA $p < 0.01$; VT $p < 0.01$; WA $p < 0.01$)

In nearly all pilots, treatment group members were more likely than control group members to receive an occupational certificate or license (Exhibit V.5). The magnitude of the statistically significant differences varied but was largest in Mississippi (for the ECCS group) and Virginia (16 percentage point difference for both) and smallest in Georgia and Washington (3 percentage point difference for both).

Exhibit V.5. Treatment–control group differences in receipt of an occupational certificate or license, by pilot



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

Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" 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.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(CA (NS) $p < 0.01$; DE $p < 0.01$; GA $p < 0.01$; IL $p < 0.01$; KS $p < 0.01$; KY $p < 0.01$; MS (ECCS) $p < 0.01$; MS (BCCS) $p < 0.01$; VA $p < 0.01$; WA $p = 0.04$)

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

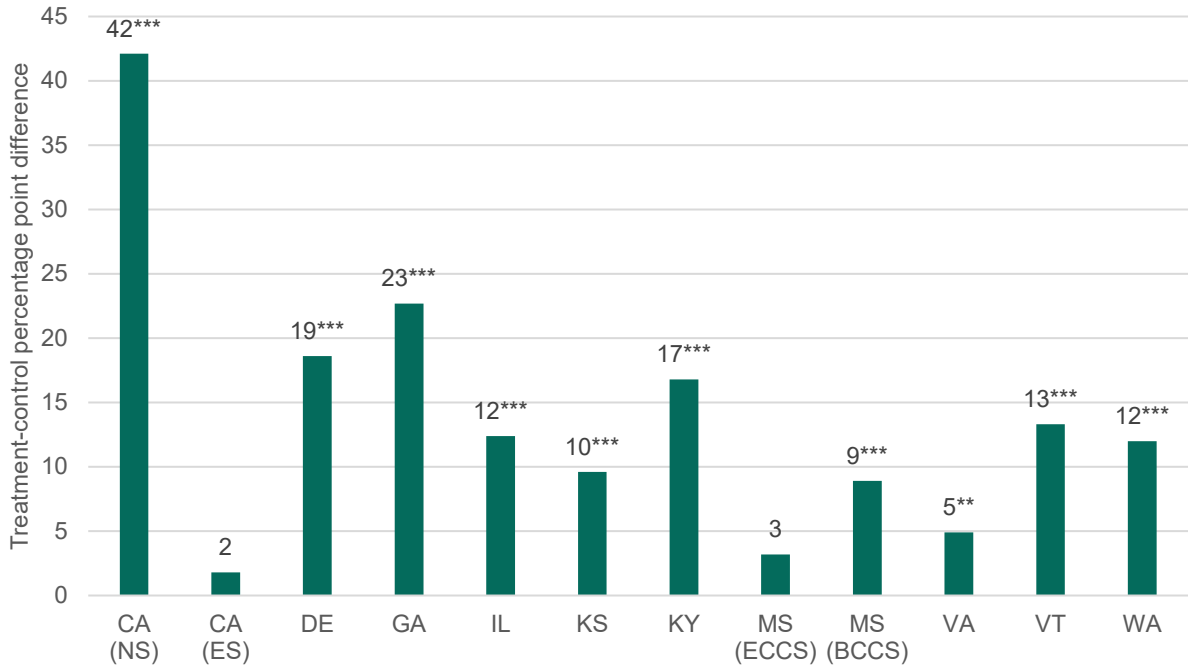
In all of the pilots, the treatment group was more likely than the control group to receive case management (Exhibit V.6).[26] Significant differences between research groups ranged from 5 percentage points in Virginia to 42 percentage points in California (for the NS control group). In the majority (8 out of 10) of pilots, the treatment group also had more contacts with an employment professional or case manager, relative to the control group (an average of 3 to 7 more contacts per person, not shown in exhibit).

Most of the pilots with the largest treatment-control differences in receipt of case management also had the highest percentages of treatment group members who received these services (Appendix Table C.4). The pilots with the largest differences between research groups in case management receipt (California [NS], Georgia, Delaware, Kentucky, and Vermont) generally offered intensive case management to treatment group members. For example, in Vermont and Kentucky staff from multiple agencies collaborated to serve treatment group members by working together to provide an individualized, team-based approach to case management. The pilot models in California and Delaware were designed to provide comprehensive case management by asking case managers to meet frequently with each treatment group member, typically on a weekly basis.[27]

[26] The receipt of case management services was assessed in the survey as receipt of "career counseling or one-on-one assistance from an employment professional or case manager". In California, there was a statistically significant difference between the treatment group and only one of the two control groups. Similarly, in Mississippi, there was a statistically significant difference between only one of the two treatment groups and the control group.

[27] The difference between research groups in case management receipt in Georgia, however, likely does not reflect an intensive case management model for treatment group members, although case management was provided as part of the pilot (treatment) model. Instead, the magnitude of the difference likely reflects that very limited case management was available to control group members as part of existing SNAP E&T. The difference between research groups in case management in Kentucky likely also reflects limited case management available to control group members in the absence of an existing SNAP E&T program. With the exception of the NS control group in California, Georgia's and Kentucky's control groups had the lowest percentage of individuals who received case management out of all the pilots (Appendix Table C.4).

Exhibit V.6. Treatment–control difference in the percentage of individuals who received career counseling or one-on-one assistance from employment professional or case manager, by pilot



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

Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" 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.

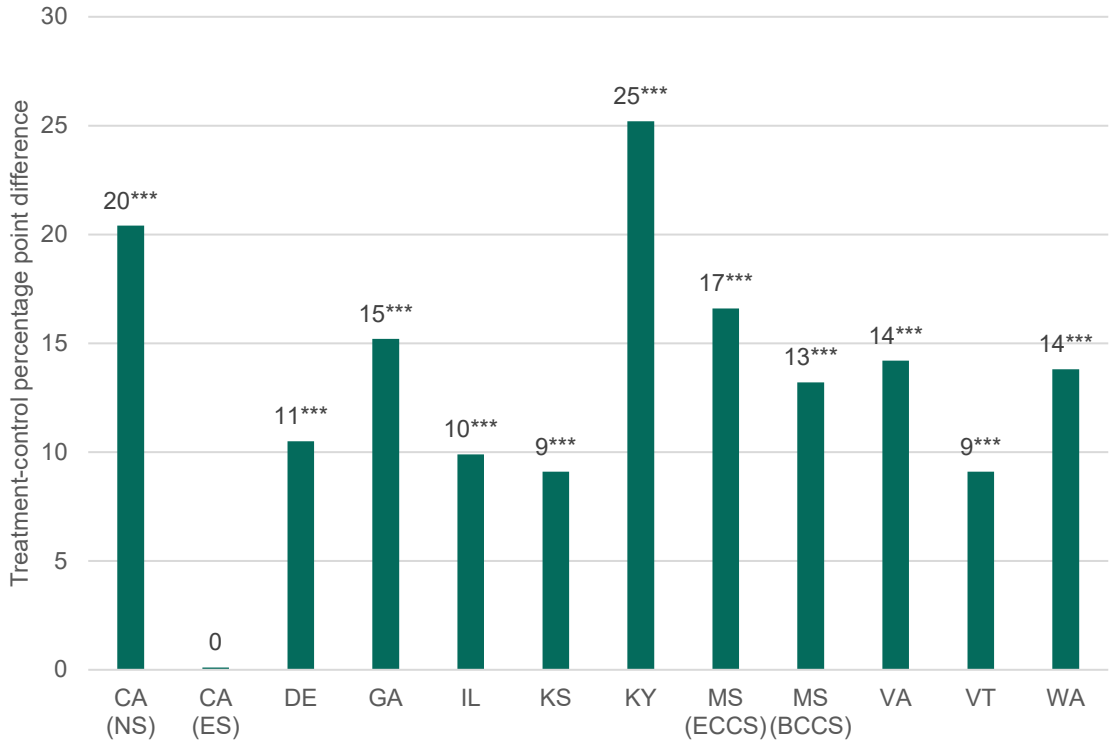
***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(CA (NS) $p < 0.01$; DE $p < 0.01$; GA $p < 0.01$; IL $p < 0.01$; KS $p < 0.01$; KY $p < 0.01$; MS (BCCS) $p = 0.01$; VA $p = 0.02$; VT $p < 0.01$; WA $p < 0.01$)

In all pilots, individuals in the treatment group were more likely than individuals in the control group to receive support services (Exhibit V.7).[28] The difference ranged from 9 percentage points in Vermont and Kansas to 25 percentage points in Kentucky. Treatment group members were more likely than control group members to receive supports in the form of transportation assistance, such as gas cards or bus passes, and support for work items such as uniforms, boots, clothes, or tools (not shown in exhibit). Research group differences in the receipt of support services were largely due to differences in control group members' receipt of services across pilots, rather than to high rates of participation in these activities among treatment group members (Appendix Table C.4). This suggests that the pilots did not differ much in their emphasis on providing support services; rather, the existing SNAP E&T and community programs provided support services to varying degrees across the pilots.

[28] In California, there was a statistically significant difference between the treatment group and only one of the two control groups (the NS control group). As described earlier in the chapter, the lack of a difference between the treatment group and the ES control group was expected at this interim stage of follow-up because the treatment group and ES group were offered similar services.

Exhibit V.7. Treatment–control group differences in the percentage of individuals who received any support service, by pilot



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

Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" 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.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.
(CA (NS) $p < 0.01$; DE $p < 0.01$; GA $p < 0.01$; IL $p < 0.01$; KS $p < 0.01$; KY $p < 0.01$; MS (ECCS) $p < 0.01$; MS (BCCS) $p < 0.01$; VA $p < 0.01$; VT $p < 0.01$; WA $p < 0.01$)

VI. CROSS-PILOT IMPACTS ON EMPLOYMENT, SNAP PARTICIPATION, AND OTHER OUTCOMES

This chapter focuses on whether treatment group members who were offered enhanced services were more likely than control group members to obtain a job, and thereby increase their incomes and reduce their need for public assistance benefits. Specifically, the chapter examines whether the generally higher rates of service receipt among individuals in the treatment group, compared with the control group (described in Chapter V), translated into impacts on employment, earnings, receipt of public assistance, and food security.

We estimated the average impacts of treatment group services on outcomes over the 12 months following random assignment. These impacts were estimated separately for each pilot by conducting t-tests to gauge whether the differences in average outcomes between the treatment and control groups were statistically significant (that is, different than zero). Before analyzing the data, we selected two primary (confirmatory) outcomes: employment (based on both the UI and survey data)[29] and SNAP participation (based on administrative records). The primary outcomes were defined over the fourth quarter after random assignment because it was the most recently observed quarter, and many treatment group members were expected to be engaged in program services shortly after random assignment, thereby reducing their employment rates during the early quarters. Although the effect of the enhanced services on earnings was an important outcome in the evaluation, we excluded it from the set of primary outcomes due to the lower statistical power of identifying an impact on earnings relative to employment. This reflects the large standard deviation of earnings for individuals enrolled in the pilot (and for the SNAP E&T population more broadly), which reduces the precision of the impact estimates. The estimated impacts on earnings and other outcomes and for subgroups are used to support findings for the primary outcomes by examining whether they fit within a pattern of similar impacts. We view these analyses as exploratory, providing policy-relevant but less rigorous evidence about program effects. This information can be valuable for continuous program improvement and for identifying potential hypotheses for more rigorous examination in the future.

All estimated impacts pertain to the offer of services (intention-to-treat [ITT] effects). These effects may differ from the impact of receiving these services (treatment-on-the-treated [TOT] effects) if some treatment group members do not take up the offer of services (and some control group members do receive services) for whatever reason. Knowing the ITT effect is important from a policy perspective because program-eligible individuals offered activities and services typically have the choice whether to participate in them. Stated differently, program non-participation is part of the policy landscape and the ITT captures this reality. The TOT is also informative because it describes program effects for those who "comply" with their treatment

[29] Each data source has advantages and disadvantages in terms of data coverage and accuracy. These are described in the 10 pilot-specific interim evaluation reports.

assignments, which is what the impact would be if program participation rates could be increased and captures the pure effect of the intervention.[30]

Overall, the treatment group services had few impacts on Quarter 4 employment (Exhibit VI.1). The enhanced services led to an increase in Quarter 4 employment in three pilots and led to a decrease in two. Similarly, impacts on Quarter 4 earnings were positive and statistically significant in only two pilots (California and Kansas, which also had positive employment impacts). In the majority of pilots, there was some indication of earnings growing faster over time for treatment group members than for control group members (not shown in exhibit), likely reflecting individuals in the treatment group completing activities and becoming employed. The evaluation's longer-term follow-up will assess whether positive impacts on employment and earnings emerged after Quarter 4.

Exhibit VI.1. Summary of treatment–control differences in employment, SNAP participation, and earnings, by pilot

	CA (NS)	CA (ES)	DE	GA	IL	KS	KY	MS (ECCS)	MS (BCCS)	VA	VT	WA
Employment (UI wage records) in Quarter 4	ns	ns	-	ns	ns	+	+	ns	ns	-	ns	ns
Employment (survey) in Quarter 4	+	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
SNAP participation in Quarter 4	ns	ns	+	ns	-	ns	ns	+	+	+	ns	+
Earnings (UI wage records) in Quarter 4	+	ns	ns	ns	ns	+	ns	ns	ns	-	ns	ns
Earnings (UI wage records) in Quarter 1	ns	ns	-	-	-	ns	ns	ns	ns	-	ns	ns
Earnings (survey) in Quarter 4	+	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Earnings (survey) in Quarter 1	ns	ns	-	ns	ns	ns	+	-	-	-	ns	ns

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

Note: CA (NS) and CA (ES) refer to the differences between the treatment group in California and the "no service" and "existing service" 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.

+ indicates that difference between research groups is positive and statistically significant at the .10 level.

- indicates that difference between research groups is negative and statistically significant at the .10 level.

ns indicates that difference between research groups is not statistically significant at the .10 level.

In all but one pilot, the availability of treatment group services did not decrease the likelihood of participation in SNAP in Quarter 4; rather, the services increased the likelihood of Quarter 4

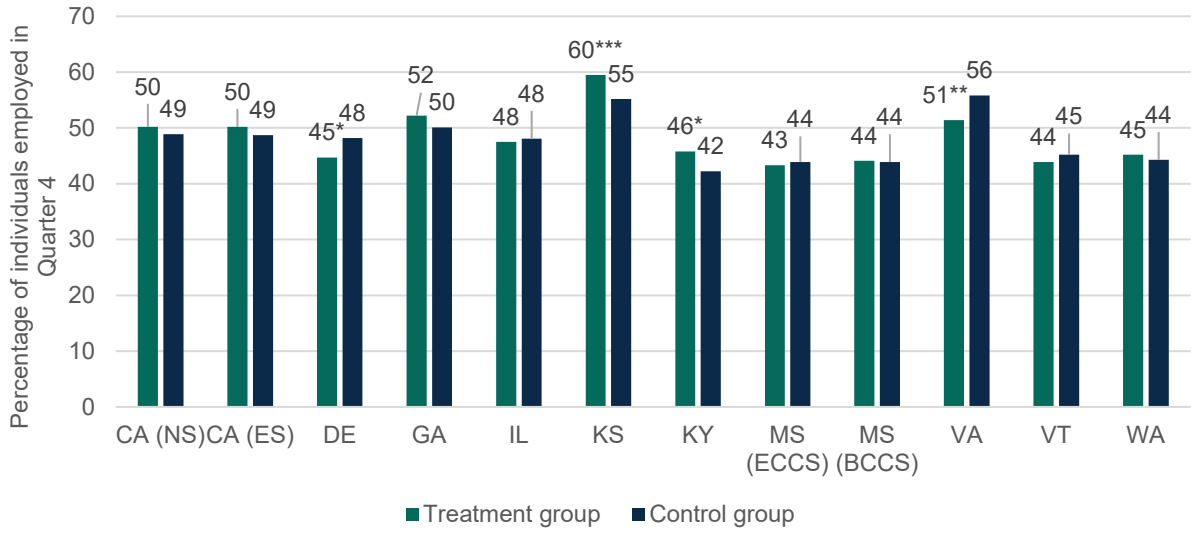
[30] In most pilots, participation rates in pilot services were high (see Chapter IV). ITT effects are therefore largely similar to TOT effects for those who actually received pilot services. Exceptions include Georgia, Illinois, and Mississippi (ECCS), where participation rates were lower. In these pilots, the TOT estimates (obtained by dividing the ITT estimates by the service participation rates) are about 50 percent larger than the ITT estimates, but significance levels are nearly identical (see Angrist et al. 1996 for a discussion of how to obtain TOT estimates from ITT estimates). Because the pattern of findings using the ITT and TOT estimates are the same, this report focuses on the ITT estimates.

SNAP participation in four pilots (Exhibit VI.1). In all pilots, SNAP participation decreased each quarter following random assignment for both research groups. In four pilots, the decrease over time in SNAP participation was smaller among the treatment group than among the control group, resulting in the treatment group being more likely than the control group to participate in SNAP in Quarter 4.

A. Impacts on Employment and SNAP participation in Quarter 4

In most (7 out of 10) pilots, the services and activities offered to the treatment group did not lead to an increase in employment in Quarter 4, based on either the UI wage records or the survey data. Based on the UI data, two pilots—Kansas and Kentucky—had significantly higher rates of employment among the treatment group relative to the control group; in both cases, the rate of employment was about 4 percentage points higher for the treatment group (Exhibit VI.2). In two other pilots—Delaware and Virginia—the opposite pattern emerged, where the UI records–based employment rate for the treatment group was about 3 and 4 percentage points lower, respectively (with rounding) than the rate for the control group. Based on the survey data, a statistically significant difference existed between treatment and control groups in the Quarter 4 employment rate in only one pilot. The rate of employment for California's treatment group was 4 percentage points higher than that of the NS control group (Exhibit VI.3).

Exhibit VI.2. Employment rate in Quarter 4 based on UI wage records, by pilot and research group



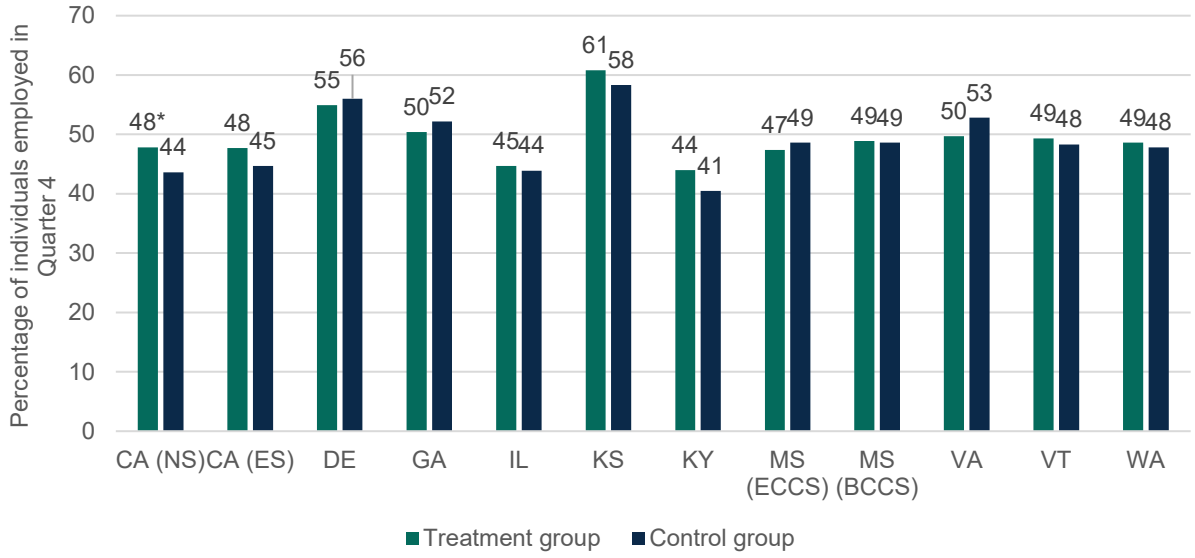
Source: SNAP employment and training evaluation UI wage records, weighted data.

Note: CA (NS) and CA (ES) refer to comparisons between the treatment group in California and the "no service" and "existing service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the comparisons between the ECCS and BCCS treatment groups in Mississippi and the control group.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(DE p = 0.09; KS p = 0.01; KY p = 0.08; VA p = 0.01)

Exhibit VI.3. Employment rate in Quarter 4 based on survey data, by pilot and research group



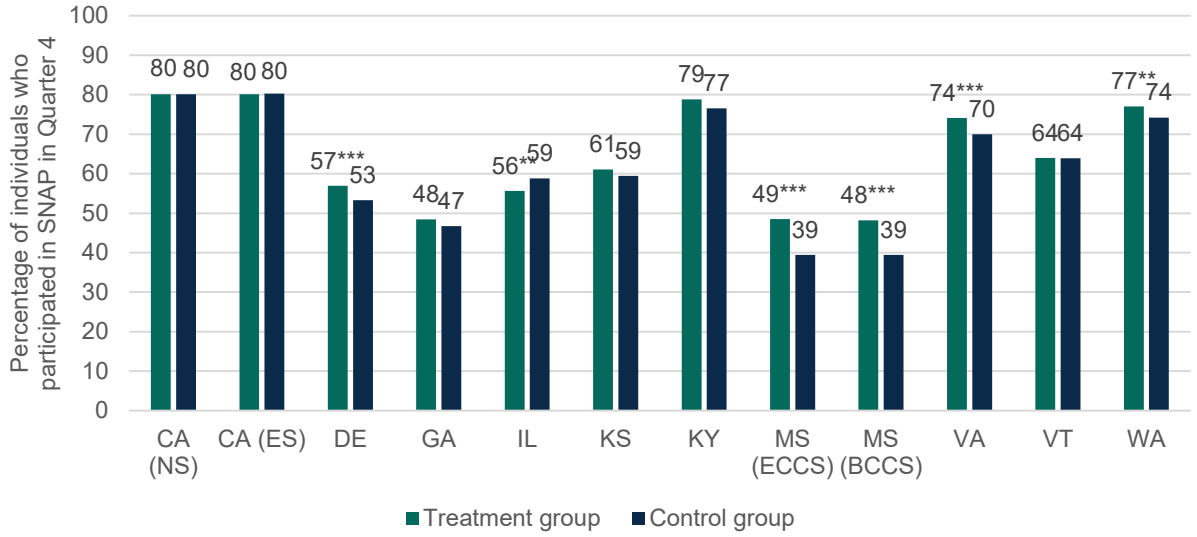
Source: SNAP employment and training evaluation 12-month survey, weighted data.

Note: CA (NS) and CA (ES) refer to comparisons between the treatment group in California and the "no service" and "existing service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the comparisons between the ECCS and BCCS treatment groups in Mississippi and the control group.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.
(CA (NS) p = 0.07)

In four pilots, the services offered to the treatment group led to a statistically greater likelihood of participating in SNAP in Quarter 4, compared with the control group. SNAP participation rates for the treatment group, relative to the control group, were 9 percentage points higher (with rounding) in Mississippi (both ECCS and BCCS programs), and were 3 to 4 percentage points higher in Delaware, Virginia, and Washington (Exhibit VI.4). 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 Quarter 4 (quarterly time trends not shown in exhibit). In Delaware, for example, between Quarters 1 and 4, SNAP participation rates decreased from 99 to 57 percent among the treatment group—a 42 percentage point change—and from 98 to 53 percent among the control group—a 45 percentage point change, resulting in a greater percentage of the treatment group participating in SNAP in Quarter 4 relative to the control group. In contrast, in one pilot, Illinois, SNAP participation in the fourth quarter was 3 percentage points lower for the treatment group than the control group. In the remaining five pilots, the availability of treatment group services had no effect on SNAP participation in Quarter 4.

Exhibit VI.4. SNAP participation rate in Quarter 4 based on SNAP administrative data, by pilot and research group



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

Note: CA (NS) and CA (ES) refer to comparisons between the treatment group in California and the "no service" and "existing service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the comparisons between the ECCS and BCCS treatment groups in Mississippi and the control group.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(DE p = 0.01; IL p = 0.02; MS (ECCS) p < 0.01; MS (BCCS) p < 0.01; VA p < 0.01; WA p = 0.02)

B. Impacts on earnings, employment, and SNAP participation throughout the one-year follow-up period

Analyses of earnings, employment, and SNAP participation in other quarters, provide useful information about changes in these measures and the associated impacts throughout the year following random assignment.

Earnings and employment in the 12 months after random assignment. In half of the pilots, earnings based on UI data grew faster over time for the treatment group than for the control group. As shown in Exhibit VI.5, the pilots fit four separate patterns of earnings impacts.

There were fewer patterns relating to changes in employment over time. In several pilots, there were no employment differences between research groups in any quarter. In several other pilots, there were positive or negative differences in employment in Quarter 1, but generally no differences in subsequent quarters. Finally, in the pilots with positive impacts on employment in Quarter 4 (California, Kansas, and Kentucky), there were generally no employment differences in earlier quarters across data sources.

Exhibit VI.5. Impacts on earnings over 12 months after random assignment based on UI data, by pilot

Pattern	Pilots
Earning for the treatment group were lower than those for the control group in early quarters, but earnings for the treatment group grew over time, resulting in no statistically significant difference between research groups in earnings in Quarter 4.	DE, GA, IL
Earnings were similar for treatment and control groups in early quarters, but earnings for the treatment group grew faster over time, resulting in statistically significantly higher earnings for the treatment group than the control group in Quarter 4.	CA, KS
Earnings were similar for treatment and control groups in most or all four quarters.	KY, MS, VT, WA
Earnings for the treatment group were lower than those for the control group in all four quarters.	VA

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

Note: California is categorized based on comparing the treatment group and the NS control group. For Georgia, Illinois, Kansas, Kentucky, Mississippi, and Virginia, findings based on the survey data differed somewhat from those based on UI data. Estimates from both data sources are reported in Appendix Tables D.1 and D.2.

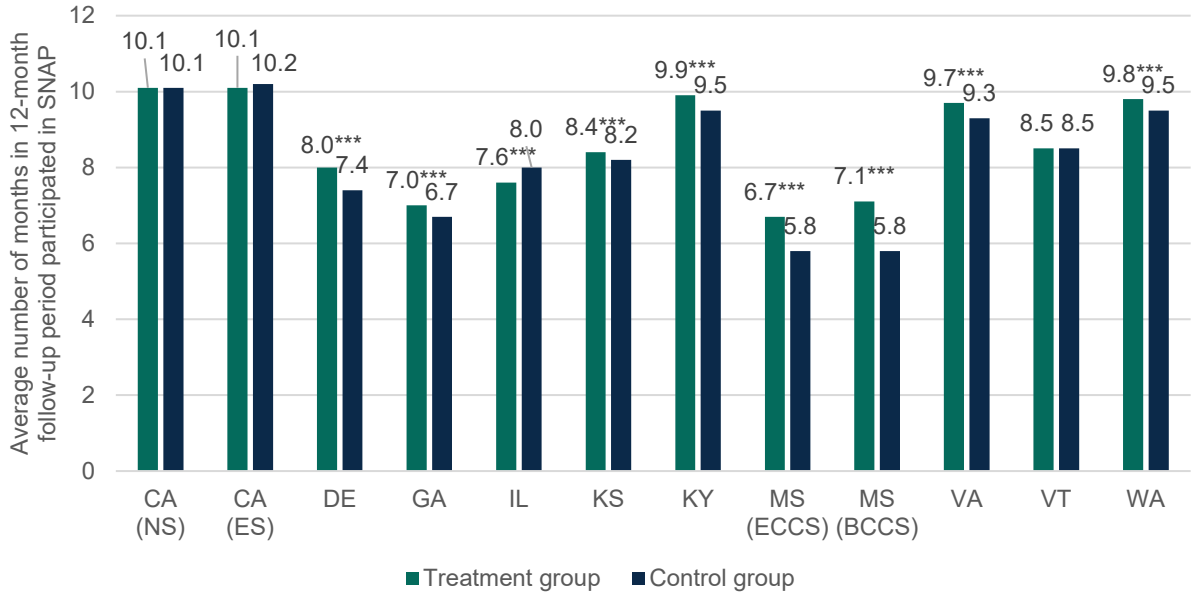
SNAP participation, benefits, and exits in the 12 months after random assignment. For the majority of pilots, the treatment group was more likely than the control group to participate in SNAP and had higher average SNAP benefit amounts in some or all quarters of the first 12 months after random assignment (Exhibit VI.6). Also, relative to the control group, the treatment group spent slightly more time participating in SNAP over the 12-month follow-up period in almost all of the pilots (Exhibit VI.7).

Exhibit VI.6. Impacts on SNAP participation over 12 months after random assignment, by pilot

Pattern	Pilots
Treatment group was more likely than the control group to participate in SNAP in some quarters.	GA, KS, KY, MS (ECCS), WA
Treatment group was more likely than the control group to participate in SNAP in all quarters.	DE, MS (BCCS), VA
SNAP participation was similar for treatment and control groups in all quarters.	CA (NS), CA (ES), VT
Treatment group was less likely than the control group to participate in SNAP in some quarters	IL

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

Exhibit VI.7. Average number of months of SNAP participation in the 12 months after random assignment, by pilot and research group



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

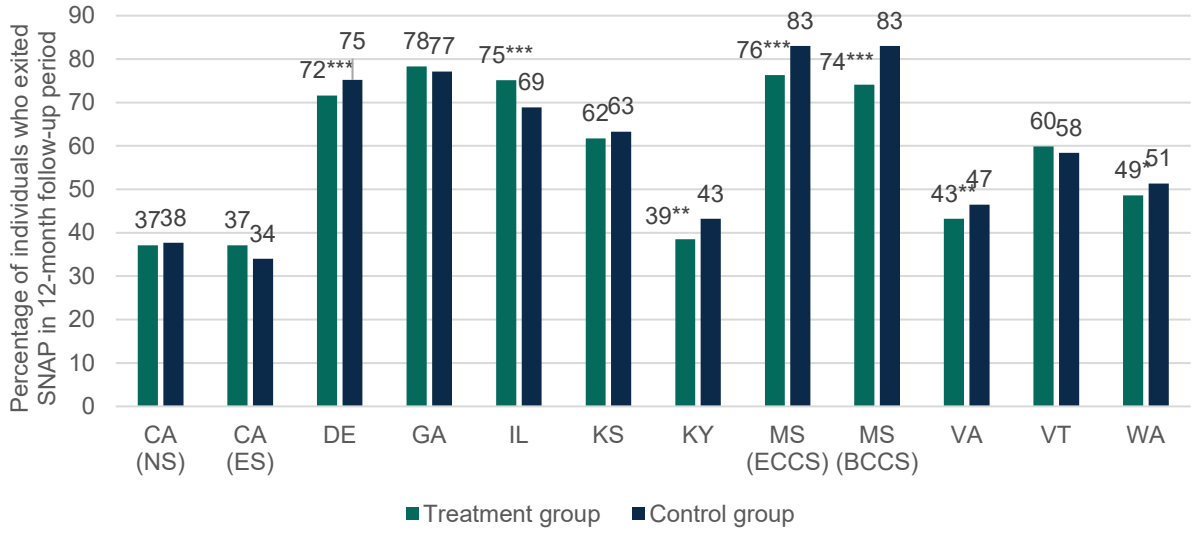
Note: CA (NS) and CA (ES) refer to comparisons between the treatment group in California and the "no service" and "exiting service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the comparisons between the ECCS and BCCS treatment groups in Mississippi and the control group.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(DE $p < 0.01$; GA $p < 0.01$; IL $p < 0.01$; KS $p = 0.01$; KY $p = 0.01$; MS (ECCS) $p < 0.01$; MS (BCCS) $p < 0.01$; VA $p < 0.01$; WA $p < 0.01$)

The majority of individuals in each research group exited SNAP within 12 months of random assignment. Among treatment group members, exit rates from SNAP were highest in Georgia (78 percent), Mississippi (76 among the ECCS group), and Illinois (75 percent)—the three States with mandatory work requirements—and were lowest in California (37 percent; Exhibit VI.8). Relative to exit rates for control group members, exit rates for treatment group members were lower in six pilots and were higher in one pilot (Illinois). Notably, in every pilot, some individuals exited and re-entered SNAP before the end of the 12-month follow-up period. For example, even though 72 percent of the Delaware treatment group exited SNAP at some point in the follow-up year, 57 percent of the treatment group was participating in SNAP at some point during Quarter 4 (not shown in exhibit).

Exhibit VI.8. Percentage of individuals who exited SNAP within 12 months of random assignment, by pilot and research group



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

Note: CA (NS) and CA (ES) refer to comparisons between the treatment group in California and the "no service" and "exiting service" control groups, respectively. MS (ECCS) and MS (BCCS) refer to the comparisons between the ECCS and BCCS treatment groups in Mississippi and the control group.

***Difference between research groups is significantly different from zero at the .01 level, two-tailed test.
**Difference between research groups is significantly different from zero at the .05 level, two-tailed test.
*Difference between research groups is significantly different from zero at the .10 level, two-tailed test.

(DE $p < 0.01$; IL $p < 0.01$; KY $p = 0.01$; MS (ECCS) $p < 0.01$; MS (BCCS) $p < 0.01$; VA $p = 0.03$; WA $p = 0.06$)

C. Impacts on food insecurity

In eight pilots, the services offered to the treatment group did not lead to a reduction in the percentage of individuals living in households that were food insecure 12 months after random assignment. This is not surprising, given that such reductions would be expected to result from increases in earnings, which were rare. In contrast, however, the rate of food insecurity was lower for the treatment group than the control group in California (6 percentage point difference) and Mississippi (11 percentage point difference for the BCCS group relative to the control group). Similarly, in eight pilots, the 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) 12 months after random assignment. However, the rate of very low food security was lower for the treatment group than the control group in Mississippi (9 percentage point difference for the BCCS group relative to the control group) and Illinois (5 percentage point difference).

D. Discussion

This section discusses the relationship between impacts on SNAP participation and impacts on employment and earnings. It also considers findings from Chapter V to examine whether the impacts track differences in service and activity receipt between research groups.

Relationship between impacts on employment and earnings and impacts on SNAP participation. For some pilots, differences in SNAP participation between research groups were to be expected, given the observed impacts on earnings or employment. For example, in two pilots (Delaware and Georgia), the treatment group had lower earnings in early quarters relative to the control group based on UI data, and, in another (Virginia), the treatment group had lower employment in Quarter 4 (Appendix table D.3). As expected, because earnings and employment were lower, the treatment group in these pilots had a statistically greater likelihood of participating in SNAP in some or all quarters, compared with the control group. In addition, there were no differences between research groups in earnings and employment in any quarter in Vermont and, correspondingly, no difference between research groups in SNAP participation.

In other pilots, the connection between SNAP participation, employment, and earnings impacts is less clear. In Kentucky and Washington, for example, earnings were similar between the research groups throughout the follow-up period, yet the treatment groups in those two pilots had a statistically greater likelihood of participating in SNAP in some or all quarters, compared with the control groups. In Kansas and California, employment was higher in Quarter 4 for the treatment groups, compared with the control groups, yet no impacts on SNAP participation emerged in Quarter 4 in these two pilots. Finally, although the pilot in Illinois did not affect the treatment group's employment and earnings in Quarters 2, 3, or 4, the pilot led to reductions in SNAP participation in Quarters 3 and 4. As discussed in the Illinois report, one possible explanation may relate to the finding that Illinois treatment group members were more likely than control group members to have been sanctioned for noncompliance in Quarters 2, 3, and 4. These sanctions may have contributed to some of the reduction in SNAP participation.

Relationship between impacts on outcomes and differences in receipt of services and activities between research groups. Cross-pilot differences in impacts on employment or SNAP participation may reflect cross-pilot differences in service and activity receipt for treatment groups versus control groups—hereafter labeled "service contrasts" for simplicity. In addition to the possible influence of the magnitude of the service contrasts, treatment–control differences in activity completion rates and the types of services that differed between research groups may explain the presence of impacts in some pilots.

Overall, we find there is no clear relationships between service contrasts and impacts on employment, earnings, or SNAP receipt observed in the 12 months after random assignment. The remainder of this section discusses these findings, first for the impacts on employment and earnings and then for the impacts on SNAP receipt.

Employment and earnings. No unique treatment–control service differences stand out for any of the three pilots in which positive Quarter 4 employment impacts were found (California (NS), Kansas, and Kentucky). California (NS) and Kentucky had large differences between research groups in participation in any activity—in job search assistance or job search training activities, or education or occupational skills training—but many other pilots also had large service contrasts and did not have impacts on employment.

Notably, there were several pilots that had larger service contrasts relative to the other pilots, but these pilots did not have an impact on employment. Mississippi (ECCS) and Georgia were among the pilots that experienced some of the largest differences in participation between research groups, and Mississippi (ECCS) had the largest difference in completion rates, but rates of employment were similar between the research groups in each pilot. Moreover, Delaware and Virginia also had statistically significant differences between research groups in participation in and completion of any activity, and these were the two pilots in which treatment group services led to a *decrease* in employment in Quarter 4.

SNAP participation. For some pilots, impacts on SNAP participation may reflect the magnitude and nature of the service contrasts across pilots. Delaware, Mississippi, Virginia, and Washington experienced higher SNAP participation in Quarter 4 among the treatment group compared to the control group, while in Illinois, SNAP participation was lower among the treatment group than among the control group. Although rates of participation in any activity were higher for the treatment group than the control group in all of these pilots, only Mississippi and Virginia were among the States with the largest service contrasts. Some of these pilots had larger service contrasts in the receipt of case management and support services, while others had relatively smaller differences, suggesting little connection between impacts on SNAP participation and case management and support services.

Increases in SNAP participation were more likely in pilots in which treatment group members had higher activity completion rates than control group members. Mississippi, Virginia, and Washington had the three largest differences in completion rates among all of the pilots and also had increases in SNAP participation. SNAP participation may be associated with higher rates of completion of education or training programs simply because participating in activities takes time, and treatment group members were only able to participate in them if they were enrolled in SNAP. Alternatively, by continuing to participate in the activity until it was completed, treatment group members may have been less likely to experience earnings increases or employment gains until after they completed the activity or program. As a result, it would have been more likely that these individuals continued to participate in SNAP during this time.

VII. ANALYSIS OF COSTS

This chapter describes the total costs of planning and implementing treatment group services through calendar year 2017. It presents data on the total costs of services; costs covered by the FNS grant versus other funding sources; and the costs of key services, including occupational skills training and case management. The costs presented in this chapter exclude those associated with the time that pilot staff spent supporting the evaluation, including activities such as random assignment.

Findings are based on cost data provided by grantees and by partners and providers that had direct contracts to provide pilot services or to help administer the pilot. Data were reported through standardized cost workbooks submitted for the planning period and on a quarterly schedule during service delivery.[31] The workbooks captured data on four core cost categories, or cost ingredients, including staff, direct service, supplies and equipment, and overhead and operating costs (Exhibit VII.1). These costs included those paid for with FNS grant funds as well as costs paid for with funds leveraged from other sources. We used the cost ingredients to estimate the total costs incurred in planning for and operating each pilot by summing costs across the four cost categories.[32]

Exhibit VII.1. Ingredients of cost estimates

Staff costs	Direct service costs	Supply and equipment costs	Overhead and operating costs
• Salaries and fringe benefits • Volunteer time	• Service contracts • Support services • Partner and provider service costs	• Supplies • Leases or purchases of equipment	• Overhead • Facilities • Utilities • Indirect costs

Notes: Cost workbooks asked for the total costs of the services provided to individuals receiving treatment group services. For all costs reported in the workbooks, respondents were asked to report the percentage of the cost that was funded by the FNS grant. Remaining costs were assumed to be covered by other sources.

Each grantee and its partners and providers submitted workbooks with their own cost information. In addition, a web survey collected data on the percentage of time provider staff spent on key services for treatment group members. Information about the average percentage of time staff spent on these services was used to allocate costs for staff, supplies and equipment, and overhead and operations to the direct services reported in the workbooks. These allocated costs were added to the costs of direct services to estimate the total cost of each service. All costs

[31] The cost workbooks asked for the percentage of time each staff member spent on evaluation activities. To exclude evaluation activities from the cost analyses, we reduced the number of hours each staff member reported spending on treatment group services by the percentage of hours he or she reported spending on evaluation activities. Information about the percentage of time spent on evaluation activities was collected for every staff member listed in the planning period and quarterly workbooks and varied over time.

[32] The ingredient methodology used for the cost data collection and analysis has been used in similar evaluations of public workforce programs and is detailed in Levin and McEwan (2001).

are based on the planning period (which began in March 2015 for all sites) through December 2017 and were adjusted to 2016 dollars—the year that pilots started incurring costs for providing treatment group services.

A. Total costs

FNS awarded grants ranging from approximately $9,000,000 to $22,330,000 to cover costs from the planning period through the end of pilot service provision. Total reported costs through 2017—including costs for the planning period and provision of treatment group services—ranged from $4,090,000 in Georgia to $15,962,000 in Washington (Exhibit VII.2). These reported costs included $197,000 to $2,283,000 for planning and $3,980,000 to $13,679,000 for service delivery. Washington reported spending at least 60 percent more than the other pilots, driven primarily by staff and overhead costs. The pilot reported more than $9 million on staffing, which, as a percentage of total costs (57 percent), was not an outlier, but the amount was generally twice that of other pilots. Washington also spent more than $5 million (or 33 percent of its total reported costs) on overhead and operating costs, which was the highest of all pilots. These costs may be due, in part, to Washington having a large number of providers (almost 40), all of which hired pilot staff and had their own overhead costs.

Exhibit VII.2. Total costs across grantees

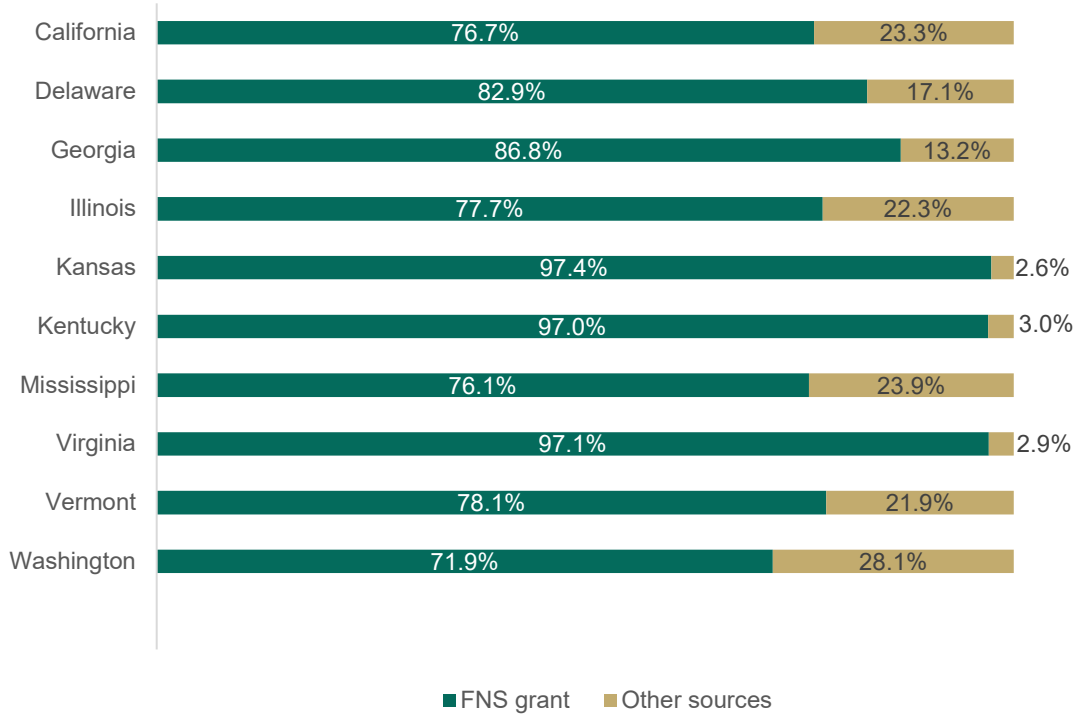
Pilot	Total grant funding	Total reported costs through 2017	Planning cost	Service delivery cost
California	$12,167,000	$6,568,000	$198,000	$6,370,000
Delaware	$18,765,000	$8,090,000	$971,000	$7,118,000
Georgia	$15,011,000	$4,090,000	$110,000	$3,980,000
Illinois	$21,858,000	$9,845,000	$280,000	$9,566,000
Kansas	$13,509,000	$5,046,000	$493,000	$4,553,000
Kentucky	$19,987,000	$7,052,000	$611,000	$6,441,000
Mississippi	$22,246,000	$5,601,000	$1,090,000	$4,511,000
Vermont	$8,959,000	$6,432,000	$197,000	$6,235,000
Virginia	$22,330,000	$8,208,000	$282,000	$7,926,000
Washington	$22,000,000	$15,962,000	$2,283,000	$13,679,000

Source: Treatment group cost workbooks, 2015–2017. Georgia reported costs through October 2017 and Virginia reported costs through November 2017.

Through December 2017, grantees and their partners and providers used FNS grant funding to cover 72 to 97 percent of total reported costs and leveraged funding from other sources to cover the remaining 3 to 28 percent of costs (Exhibit VII.3). Funding from other sources came from grantees, partners, and providers. For some grantees, funding from other sources came from many partners and providers (such as in Illinois), while in others, a single provider was responsible for the majority of the leveraged resources (such as in Vermont). Often, the non-

grant funding covered staff time (such as time from leadership or administrators at various organizations who donated time), office space or facilities, or a share of training costs (such as instructors' time or materials).

Exhibit VII.3. Funding sources across grantees



Source: Treatment group cost workbooks, 2015–2017.

Notes: Cost workbooks asked for the total costs of the services provided to individuals in the treatment group. For all costs reported in the workbooks, respondents were asked to report the percentage of the cost that was funded by the FNS grant. Remaining costs were assumed to be covered by other sources.

B. Service-specific costs

We estimated the costs of direct services including assessments, job readiness or life skills workshops, education, occupational skills training, work-based learning, support services, case management (including one-on-one meetings with participants, or time spent on case notes or referrals), or other direct service contracts. For many pilots, most of the reported costs during the planning period and first 18 months of operations were related to administration (meaning activities not related to direct services), including planning and development, management and oversight, and recruitment and enrollment. Seven of the 10 grantees spent more than half of total costs through December 2017 on administration activities (Exhibit VII.4). The remaining costs were for direct services and represented 14 to 75 percent of total costs.[33] Direct service costs

[33] Virginia reported spending 91 percent of total costs through December 2017 on direct service activities, but this estimate is likely overstated. Virginia provided only the total contract amount paid to each provider for services rather than a breakdown of any potential administrative costs the provider incurred. Therefore, all contract costs

likely will represent a larger share of total costs when costs throughout the entire pilot operational period—including 2018 and 2019 expenditures—are analyzed.

Exhibit VII.4. Estimated costs of administration and direct service delivery

Grantee	Total costs	Percentage of total costs	
		Administration[a]	Service delivery
California	$6,568,000	74.3	25.7
Delaware	$8,090,000	83.1	16.9
Georgia	$4,090,000	85.7	14.3
Illinois	$9,845,000	59.5	40.5
Kansas	$5,046,000	63.1	36.9
Kentucky	$7,052,000	24.8	75.2
Mississippi	$5,601,000	72.3	27.7
Vermont	$6,432,000	43.6	56.4
Virginia	$8,208,000	9.0	91.0[b]
Washington	$15,962,000	77.4	22.6

Sources: Treatment group cost workbooks and time-use survey data, 2015–2017.

Notes: The estimated costs of service delivery include several service types: case management, structured group activities, formal assessments, support services, other direct service contracts, work-based learning, occupational skills training, and education.

[a]Administration costs, or other non-direct service costs, include service contracts that cannot be assigned to one of the defined direct services, such as a subcontract for recruiting services. Other administration/non-direct service costs include the costs of other pilot-related activities that are not direct services, including the planning period costs, administration, recruitment and enrollment, and staff meetings and supervision.

[b]Virginia provided only the total contract amount paid to each provider for services rather than a breakdown of any potential administrative costs the provider incurred. Therefore, all contract costs were applied to direct service costs. This is likely understating the administrative costs for operating the pilot and overstating the direct service costs for these providers.

The percentage of total costs pilots spent on different types of direct services varied. Some pilots had several direct services that represented a large percentage of costs, such as Kentucky, which spent almost half of total costs on work-based learning and support services, and Vermont, which spent almost a third of costs on case management and support services (Exhibit VII.5). Other pilots' costs were distributed more evenly across types of direct services where, in general, no specific service represented more than 10 percent of total costs.

were applied to direct service costs. This is likely understating the administrative costs for operating the pilot and overstating the direct service costs for these providers.

Exhibit VII.5. Percentage of total costs spent on different types of direct services (and administration)

Type of direct service	California	Delaware	Georgia	Illinois	Kansas	Kentucky	Mississippi	Virginia	Vermont	Washington
Assessments	1.6	2.0	4.4	4.6	3.3	1.2	2.7	0.8	2.6	2.0
Job readiness or life skills workshops	6.1	2.0	2.0	6.6	4.5	0.6	5.3	63.1	5.1	4.2
Education	0.2	0.0	0.0	0.7	8.6	12.8	0.1	4.1	0.2	0.4
Occupational skills training	5.0	1.9	3.6	10.0	1.2	4.6	3.6	6.3	0.6	0.3
Work-based learning	4.5	0.0	0.2	6.1	0.0	21.6	5.1	0.0	9.1	1.5
Support services	2.0	1.8	0.1	3.6	7.9	22.3	4.2	3.7	16.2	4.7
Case management	6.3	5.9	4.0	5.9	9.5	10.3	6.8	11.0	13.3	9.5
Other direct service contracts	0.0	3.2	0.0	3.0	1.8	1.4	0.0	2.0	9.3	0.0
Administration (non-direct service costs)[a]	74.3	83.1	85.7	59.5	63.1	24.8	72.3	9.0	43.6	77.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Sources: Treatment group cost workbooks and time-use survey data, 2015–2017.

Notes: The costs of different types of direct services were estimated in different ways. Case management, job readiness or life skills workshops, and formal assessments include costs for staff, supplies and equipment, and overhead and operating costs, which were allocated using the average percentage of time spent on these activities in the time-use survey. The estimated costs of support services, other direct service contracts, work-based learning, occupational skills training, and education do not include costs for staff, supplies and equipment, or overhead and operating costs. We assumed these costs were either built into those payments, or the associated staff time and costs were represented as case management. All costs are presented in 2016 dollars.

[a]Administration costs, or other non-direct service costs, include service contracts that cannot be assigned to one of the defined direct services, such as a subcontract for recruiting services. Other non-direct service costs include the costs of other pilot-related activities that are not direct services, including the planning period costs, administration, recruitment and enrollment, and staff meetings and supervision.

VIII. CONCLUSION

The goal of the 10 SNAP E&T pilots was to provide enhanced services intended to increase SNAP participants' employment and earnings and reduce their need for public assistance benefits. Through a comprehensive data collection effort and rigorous experimental design, the evaluation of the 10 pilots assessed whether the enhanced services each State designed and implemented were effective in achieving these outcomes. This chapter summarizes the report's main findings, which are preliminary findings covering a one-year period after SNAP participants' random assignment dates.

A. Summary of main findings

This section summarizes the main findings from the analysis of implementation data, treatment group members' service receipt, pilot costs, and differences between research groups in service receipt. It also discusses findings from the impact analyses and considerations regarding whether longer-term impacts may be expected.

1. Pilot characteristics and services offered

Across all pilots, State SNAP agencies partnered with service providers and non-providers that helped administer the pilots. Most of the pilots were voluntary (only three pilots operated mandatory programs) and offered pilot services in selected areas of the State; two States administered statewide pilots. All of the pilots targeted work registrants, but a few targeted subsets of this population, including ABAWDs or individuals with significant barriers to employment.

The activities and services offered to the treatment group generally were more expansive than those offered under existing SNAP E&T programs. The existing SNAP E&T programs in States that offered them generally provided a limited set of services, with most focusing on independent or structured job search and workfare. Some programs offered education and occupational skills training activities, but typically a small number of individuals participated in these activities. All of the pilots offered some case management and support services as part of their existing SNAP E&T program, but case management was limited and supports were generally small.

In contrast, pilot services typically included (1) a comprehensive skills and 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, such as transportation assistance, housing assistance, and training or work supplies (for example, uniforms, books, clothes, or tools) that supported individuals' involvement in activities designed to reduce barriers to employment. In addition, pilots offered a range of activities, such as job readiness training, job search assistance, basic education, occupational skills training, and subsidized employment.

Despite offering many activities and services, pilots generally focused on a subset of these for which they intended most individuals to receive. When identifying the top two most prominent

activities for each pilot, occupational skills training was most common (seven pilots). About half of the pilots also focused more on job search assistance or training than on most other types of activities. Only a few pilots focused more on basic education or work-based learning than on most other types of activities.

2. Implementation findings

All of the grantees developed services, created partnerships, and began enrolling individuals into their pilots within about one year of grant award. The amount of work required during the planning period was significant, but all States, despite some challenges, were able to begin pilot enrollment with most services in place. Overall, the models were generally implemented as intended, with some changes made over time to respond to treatment group members' and staff's needs.

Despite these achievements, most pilots faced challenges during the planning and implementation periods that likely affected how well the pilots were implemented and the outcomes of individuals enrolled in the pilots. Several key findings emerged across pilots in this early period. These findings include both strengths of the implementation and challenges pilots faced, which provide context for the 12-month follow-up findings, and can provide lessons for implementing similar efforts:

- Strategic partnering was important for most pilots because SNAP agencies often were not able to provide particular services directly or existing SNAP E&T program providers did not offer a robust set of services. Pilot staff often cited partnerships with providers or non-providers as one of their major accomplishments under the pilot, but partnerships also proved to be challenging for many pilots. 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, leading to challenges in communication between organizations and differing organizational missions or cultures. Teaming with organizations that had not previously worked together also required extensive coordination and time to develop relationships. Developing and launching services that did not exist before was particularly challenging, even when partnering with established partners and providers. Although many of the pilots were expanding an existing set of services or adding services that already were being provided to other groups, a few pilots created entirely new services or provided services in areas where SNAP E&T services had not previously been available. These more extensive development processes were often challenging and sometimes resulted in delayed implementation.
- Despite the pilots offering an array of activities, take up and completion of education, occupational skills training, and work-based learning activities were often lower than anticipated. Several factors contributed to low take-up rates, including individuals' lack of interest in the offered services or willingness to enter lengthy trainings, barriers to participating in these activities, and challenges pilot staff faced in implementing certain activities (which limited the availability of those activities).

- The design of the service models also sometimes affected rates of take up and completion of services. After implementing the planned models, management in several of the pilots realized the model was not working as planned and was affecting how or to what degree individuals engaged in services. This was a result of pilot staff initially not fully understanding the characteristics or interests of the populations the pilot served; the model having multiple "hand-off" points or upfront requirements before individuals could enter employment, education, and training activities; or the model not accounting for the flow of individuals into the pilot versus the timing of activities being available, which led to extensive waiting periods before education or occupational skills training activities started.
- Robust support services, particularly transportation assistance, were key to getting individuals into activities and keeping them engaged. All of the pilots offered support services, and in many pilots both pilot staff and individuals participating in the pilots (during focus groups) frequently discussed the importance of support services in ensuring individuals could mitigate barriers to participation, engage in activities, and work toward their goals. Although several of the pilots provided extensive supports, most still faced challenges in helping individuals mitigate significant barriers that the supports could not fully address, often related to transportation and housing.

3. Treatment group members' service receipt

Overall initial engagement in the pilots was generally high for most pilots—at least 80 percent of individuals assigned to the treatment group started pilot intake, assessments, or an employment or training-related activity—but participation rates in particular activities and of receipt of services varied. Despite high rates of initial engagement, generally fewer treatment group members ultimately started an employment or training-related activity after they completed intake and assessments—in eight pilots, 65 percent or less of individuals started an activity. Take up of specific activities was lower, with job search training or assistance having the highest take up across pilots—45 percent or more of individuals in seven pilots participated in this type of activity. Fewer individuals participated in occupational skills training or work-based learning—25 percent or more of individuals participate in occupational skills training in only four pilots (across all pilots the rates ranged from 5 to 43 percent), and in work-based learning in only two pilots (across all pilots the rates ranged from less than 1 percent to 34 percent).

Although not all treatment group members participated in activities, most did receive case management and support services while engaged in the pilot. Nearly all of the individuals in seven pilots had at least one contact with a case manager. The percentage of individuals who received any type of support service varied much more across the pilots, but generally 50 to 70 percent of treatment group members received a support while in the pilot, most commonly transportation assistance.

Exit rates also were relatively high in most pilots, with 70 percent or more of individuals in seven pilots exiting within their first year of follow-up (four pilots had exit rates of 90 percent or more). Of those who exited, most individuals left the pilot 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. Few individuals (30 percent or less across pilots) exited the pilot due to completing all pilot activities or finding employment (based on self-reporting).

4. Differences between treatment and control groups in service receipt

Whether impacts on employment and SNAP participation result from the enhanced services provided through the SNAP E&T pilots depends, in part, on the degree to which there is a difference between treatment and control group members in the type, incidence, or amount of services received. The findings in the report suggest there was a contrast in service take-up and completion between individuals in the treatment and control groups in all pilots.[34] In each pilot, the treatment groups were more likely than the control groups to participate in some type of activity—job search assistance or job search training activities, or education or occupational skills training—within the 12-month follow-up period. Overall, differences between research groups in participation in these types of activities were at least 15 percentage points higher for the treatment group in about half of the pilots. The finding that all pilots were able to increase treatment group members' participation in activities to levels higher than those of their respective control groups suggests that it is possible to improve engagement in these types of activities, regardless of the types of services and activities offered and the populations targeted.

In almost all pilots, relative to the control group, the treatment group had higher completion rates for education and training programs and was more likely to receive an occupational certificate or license. In all pilots, the treatment group was more likely than the control group to receive case management, and, in the majority of pilots, the treatment group also had more contacts with an employment professional or case manager. Similarly, in all pilots, the treatment group was more likely than the control group to receive support services.

Some individuals were still in activities at the end of the 12-month follow-up period, so some of the differences between research groups regarding aspects of participation in services and activities could change with longer follow-up. In addition, these contrasts could change when data on all individuals enrolled in the pilots are available.

5. Short-term impacts on employment, SNAP participation, and other outcomes

An examination of employment and SNAP participation in the fourth quarter of follow-up—the evaluation's two primary outcomes—showed that the treatment group services had few impacts on employment and did not decrease the likelihood of participation in SNAP; rather, the services increased the likelihood of Quarter 4 participation in SNAP in four pilots.

The pilots' enhanced services led to an increase in Quarter 4 employment in 3 pilots (California [NS group], Kansas, and Kentucky), and led to a decrease in 2 pilots (Delaware and Virginia). Similarly, impacts on Quarter 4 earnings were positive and statistically significant in only two pilots (California and Kansas). In the majority of pilots, there was some indication of earnings growing faster over time for treatment group members than for control group members (with treatment group members having lower earnings than control group members in the first follow-

[34] In California, this was true when comparing the treatment and NS control group. There was no difference when comparing the treatment and ES control group.

up quarter) based on either UI or survey data, likely reflecting individuals in the treatment group completing activities and becoming employed. At the same time, in all pilots, SNAP participation decreased each quarter following random assignment for both research groups. In almost half of the pilots, however, there was a smaller decrease over time in SNAP participation among the treatment group than among the control group, resulting in the treatment group being more likely than the control group to participate in SNAP in Quarter 4.

The findings related to SNAP participation generally make sense given the patterns of changes in earnings and employment over the first follow-up year for treatment and control group members. Conceptually, SNAP E&T services are designed to increase individuals' employment and earnings and, thus, reduce their need for SNAP or other public assistance. In several pilots (Delaware, Georgia, Mississippi, Virginia, and Washington), there was either no change in employment or a decrease in employment over the year, and there were quarters in which earnings were lower for the treatment group than for the control group. This increased the likelihood that treatment group members would continue to be eligible for and participate in SNAP—or conversely, decreased the likelihood that they would exit SNAP. In several other pilots (California and Vermont), employment and earnings were similar for treatment and control group members in most or all quarters in the year, making it unlikely that an impact on SNAP participation in the follow-up period would be observed. In two pilots (Kansas and Kentucky), treatment group members were more likely than control group members to be employed in Quarter 4, but SNAP participation rates did not differ between research groups, possibly reflecting that employment and earnings were similar across research groups in most other quarters of the follow-up year. In Illinois, employment and earnings were similar for the treatment and control groups, but SNAP participation was lower among the treatment group, possibly reflecting higher sanction rates due to noncompliance for treatment group members compared with control group members in several quarters of the follow-up period. Finally, when we examined whether desirable impacts on labor market outcomes and SNAP participation were present (or larger) in pilots which had larger contrasts between research groups in employment and training activity receipt, a clear relationship was not apparent across the pilots between the magnitude of service receipt contrast and impacts on employment, earnings, and SNAP receipt.

These findings do not imply that the services provided to the treatment group in each pilot will not eventually be effective in achieving the goals of increasing employment and reducing the need for public assistance. In fact, past studies of workforce programs have shown that it can take more than a year before economic impacts emerge (Card et al. 2010, 2018; D'Amico et al. 2015). Indeed, treatment group members' participation in education and training was highest in the early quarters of follow-up in most pilots, likely displacing employment during this period. Results from the longer-term follow-up period to appear in the final evaluation report, which will extend up to three years from an individual's date of random assignment, are needed to fully assess the impacts of these services.

6. Pilot costs

FNS awarded grants ranging from approximately $9,000,000 to $22,330,000 to cover States' costs from the planning period through the end of service provision. The pilots reported costs

ranged from $4,090,000 to $15,962,000 (22 to 73 percent of total grant) through December 2017 for planning and implementing treatment group services. Approximately 3 to 19 percent of these costs were for planning; the remaining funds were spent on service delivery (between $3,980,000 and $13,679,000). Most of the costs were allocated to administration (activities not related to direct services), including pilot planning and development, management and oversight, and recruitment and enrollment. Seven of the ten grantees spent more than half of total costs through December 2017 on administration activities. The remaining costs were for direct services and represented between 14 percent and 75 percent of total costs.[35] Direct service costs likely will represent a larger share of total costs when costs throughout the entire pilot operational period—including 2018 and 2019 expenditures—are analyzed and reported.

B. Final report

This report presents a preliminary assessment of the effects of the pilots' enhanced services on individuals' employment, earnings, and SNAP participation. In most pilots, the findings are based on information from only a portion of all individuals enrolled in the pilot—those who enrolled through December 2017—and cover only the first year following random assignment for each individual. Furthermore, the report's cost findings cover only the pilot planning and early implementation periods. For these reasons, the short-term outcomes presented in this report do not fully capture the potential effects of treatment group services on labor market and public assistance outcomes, or the pilot's full costs. Notably, some individuals (8 to 29 percent of treatment group members, depending on the pilot) were still receiving services at the 12-month point. In addition, most pilots continued to enroll and provide services to individuals in 2018 and 2019. An upcoming final report will examine the experiences of all individuals enrolled in the pilots, present their outcomes over a period of up to 36 months after random assignment, and examine the benefits of the pilots' services relative to their full costs. In doing so, the final report will provide comprehensive and conclusive evidence about the effectiveness of the pilots.

[35] Virginia reported spending 91 percent of total costs through December 2017 on direct service activities, but this estimate is likely overstated. Virginia provided only the total contract amount paid to each provider for services rather than a breakdown of any potential administrative costs the provider incurred. Therefore, all contract costs were applied to direct service costs. This is likely understating the administrative costs for operating the pilot and overstating the direct service costs for these providers.

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Appendix

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

Grantee	Implementation site visit dates	Administrative service use data cohorts	12-month survey data cohorts[b]	UI wage records cohorts	SNAP administrative data cohorts	Cost data[d]
Follow-up period		**12 months**	**12 months**	**4 quarters**	**12 month[c]**	
California	July 2016 June 2017	01/2016 – 07/2017	01/2016 – 07/2017	01/2016 – 06/2017	01/2016 – 07/2017	Costs from 04/2015 – 12/2017
Delaware	July 2016 June 2017	02/2016 – 12/2017	02/2016 – 12/2017	02/2016 – 03/2017	02/2016 – 12/2017	Costs from 04/2015 – 12/2017
Georgia	July 2016 June 2017	02/2016 – 12/2017	02/2016 – 12/2017	02/ 2016 – 06/2017	02/2016 – 12/2017	Costs from 04/2015 – 10/2017
Illinois	August 2016 May 2017	03/2016 – 10/2017	03/2016 – 10/2017	03/ 2016 – 03/2017	03/2016 – 12/2017	Costs from 04/2015 – 12/2017
Kansas	June 2016 June 2017	01/2016 – 12/2017	01/2016 – 12/2017	01/2016 – 09/2017	01/2016 – 12/2017	Costs from 04/2015 – 12/2017
Kentucky	September 2016 July 2017	04/ 2016 – 12/2017	04/2016 – 12/2017	04/2016 – 06/2017	04/2016 – 12/2017	Costs from 07/2015 – 12/2017
Mississippi	August 2016 June 2017	03/2016 – 12/2017	03/2016 – 12/2017	03/2016 – 03/2017	03/2016 – 12/2017	Costs from 04/2015 – 12/2017
Vermont	August 2016 May 2017	03/2016 – 12/2017	03/2016 – 12/2017	03/2016 – 03/2017	03/2016 – 12/2017	Costs from 04/2015 – 12/2017
Virginia	July 2016 June 2017	03/2016 – 12/2017	03/2016 – 12/2017	03/2016 – 06/2017	03/2016 – 11/2017	Costs from 03/2015 – 11/2017
Washington	June 2016 June 2017	02/2016 – 12/2017	02/2016 – 12/2017	02/2016 – 03/2017	02/2016 – 12/2017	Costs from 04/2015 – 12/2017

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 survey.

[c]In Kentucky, Mississippi, Virginia, Vermont, and Washington, 11 months of data were used for individuals who were randomly assigned in December 2017.

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

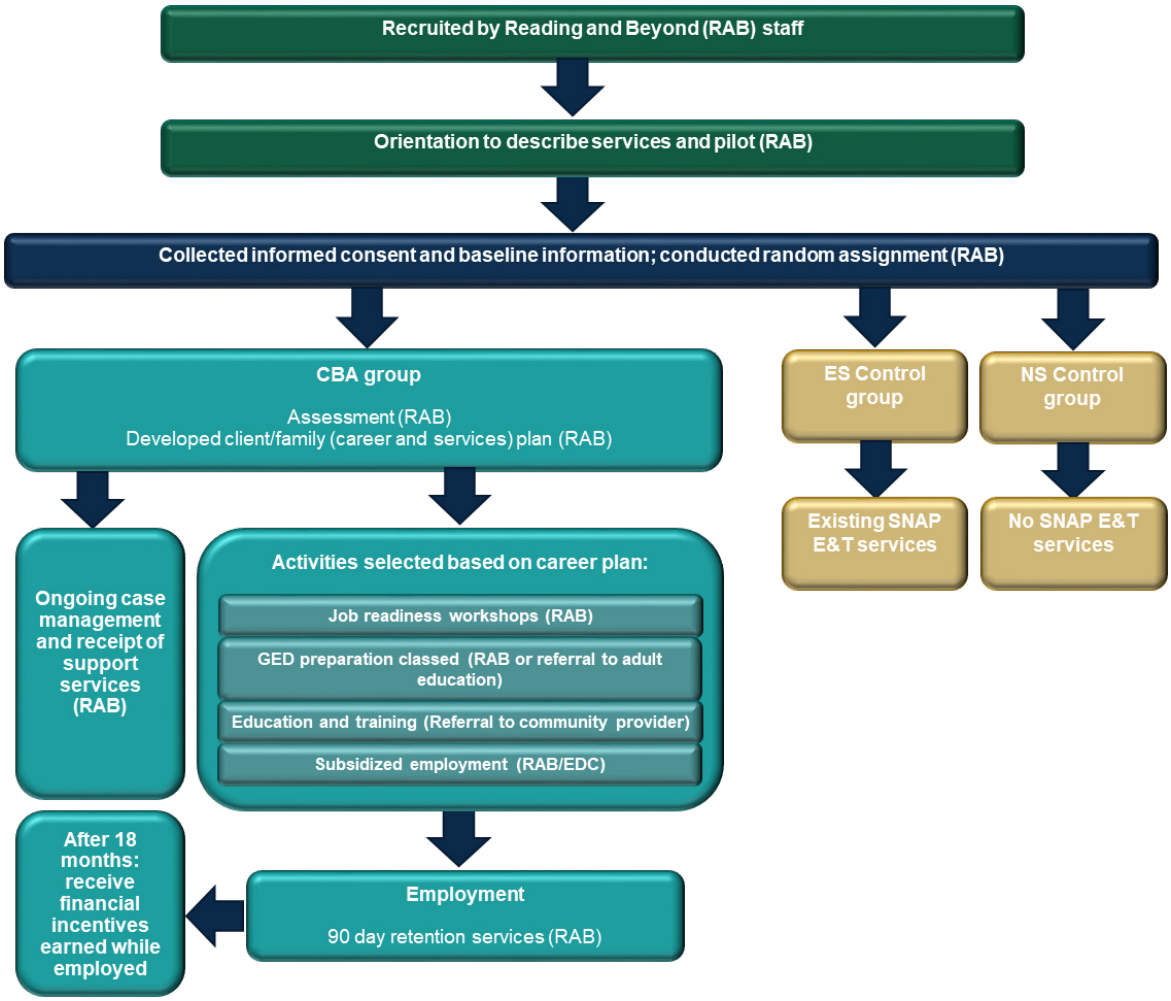
Appendix Table A.2. Number of treatment and control group members, by data source

	Administrative service use data	12-month survey data		UI wage records		SNAP administrative data	
Pilot	Treatment group	Treatment group	Control group	Treatment group	Control group	Treatment group	Control group
California (NS)	1,797	1,044	838	1,797	1,465	1,797	1,465
California (ES)	1,797	1,044	363	1,797	633	1,797	633
Delaware	2,672	1,042	1,049	1,057	1,066	2,672	2,672
Georgia	2,291	1,273	1,198	1,698	1,709	2,291	2,305
Illinois	2,504	1,237	1,194	1,627	1,642	2,503	2,509
Kansas	1,987	926	855	1,727	1,712	1,987	1,974
Kentucky	1,259	673	582	987	987	1,262	1,274
Mississippi (ECCS)	737	399	368	391	392	737	735
Mississippi (BCCS)	736	415	368	387	392	736	735
Virginia	1,925	1,131	1,110	1,293	1,285	1,925	1,911
Vermont	1,378	664	587	1,156	1,142	1,378	1,378
Washington	2,186	797	779	1,818	1,818	2,235	2,231

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

Note: California (NS) and California (ES) refer to the “no service” and “existing service” control groups in California, respectively. Mississippi (ECCS) and Mississippi (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi.

Appendix Table B.1. California's client flow and pilot pathways

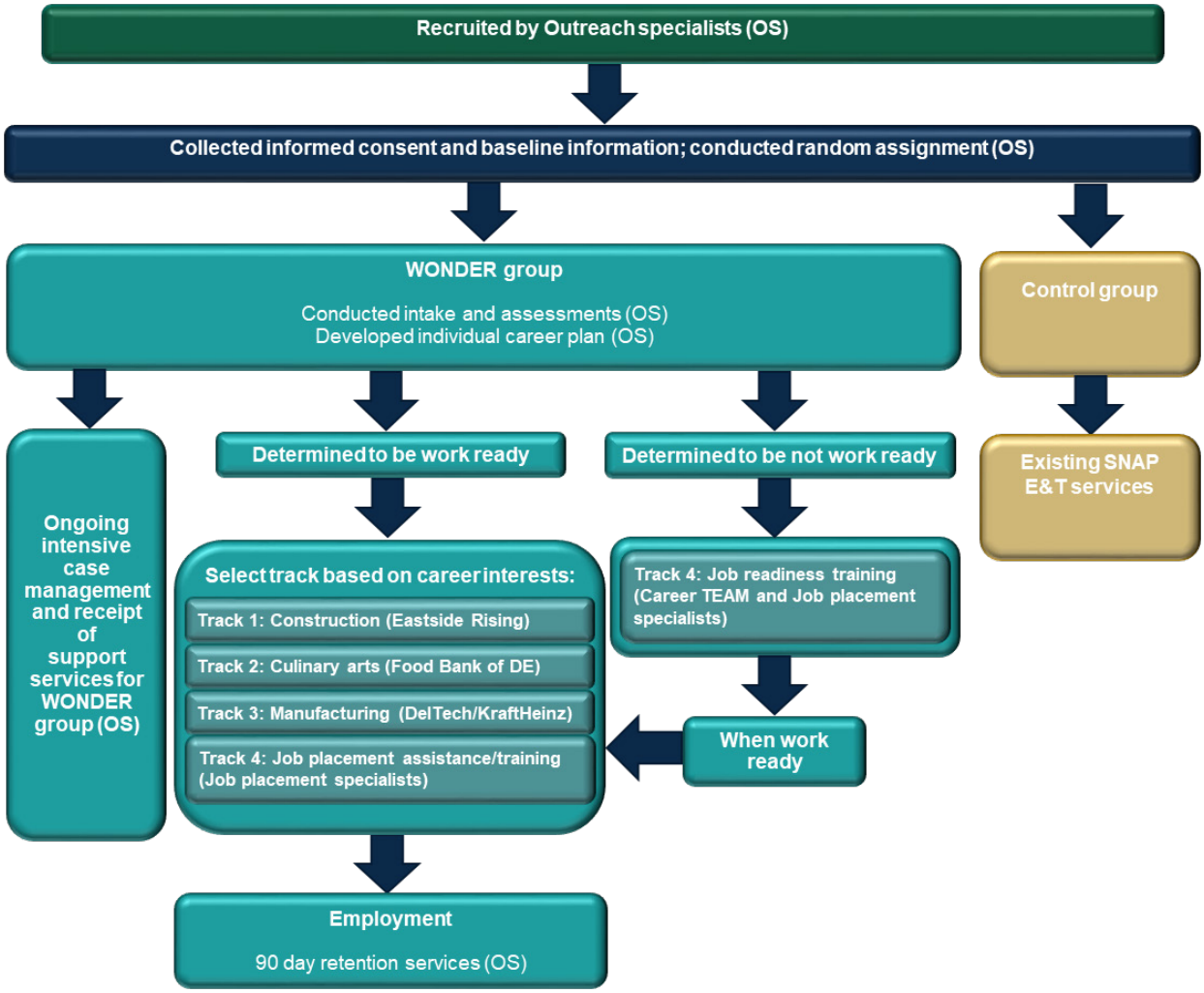


Note: A complete written description of California's client flow and pilot pathways can be found in Chapter II, Section C of the California Interim Evaluation Report.

CBA = California Bridge Academy

EDC = Fresno County Economic Development Corporation

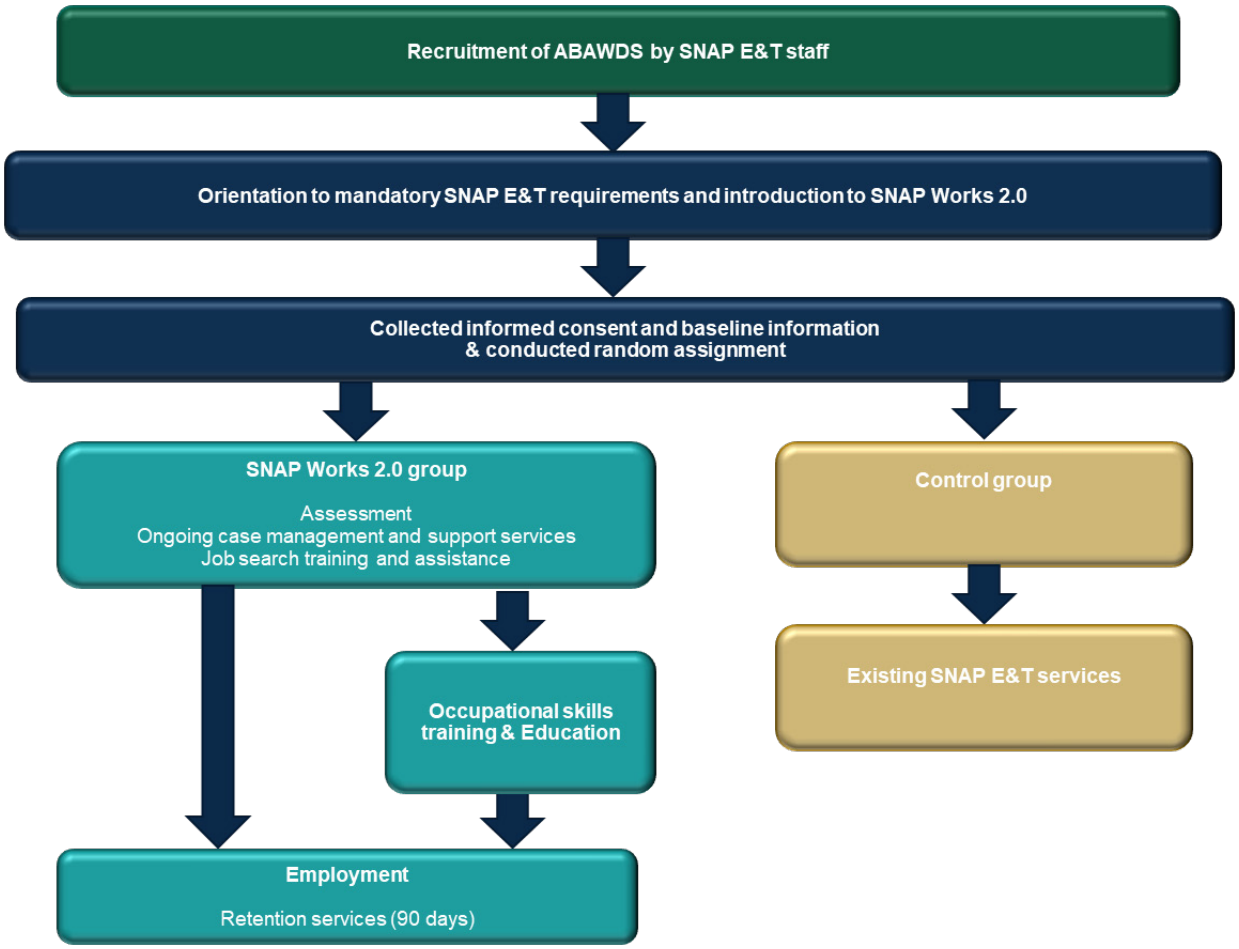
Appendix Table B.2. Delaware's client flow and pilot pathways



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

WONDER = Work Opportunity Networks to Develop Employment Readiness

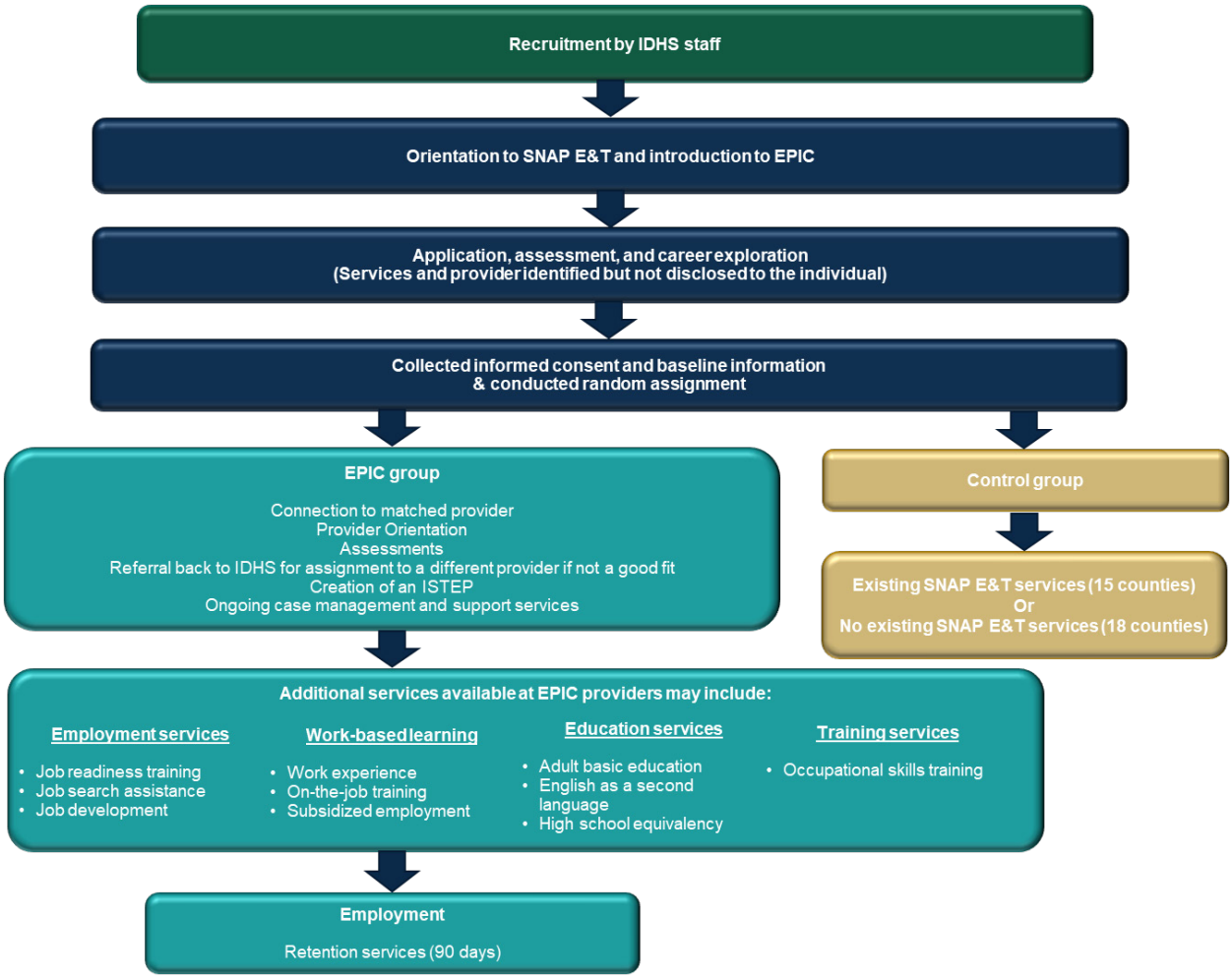
Appendix Table B.3. Georgia's client flow and pilot pathways



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

DCF = Division of Family and Children Services

Appendix Table B.4. Illinois' client flow and pilot pathways



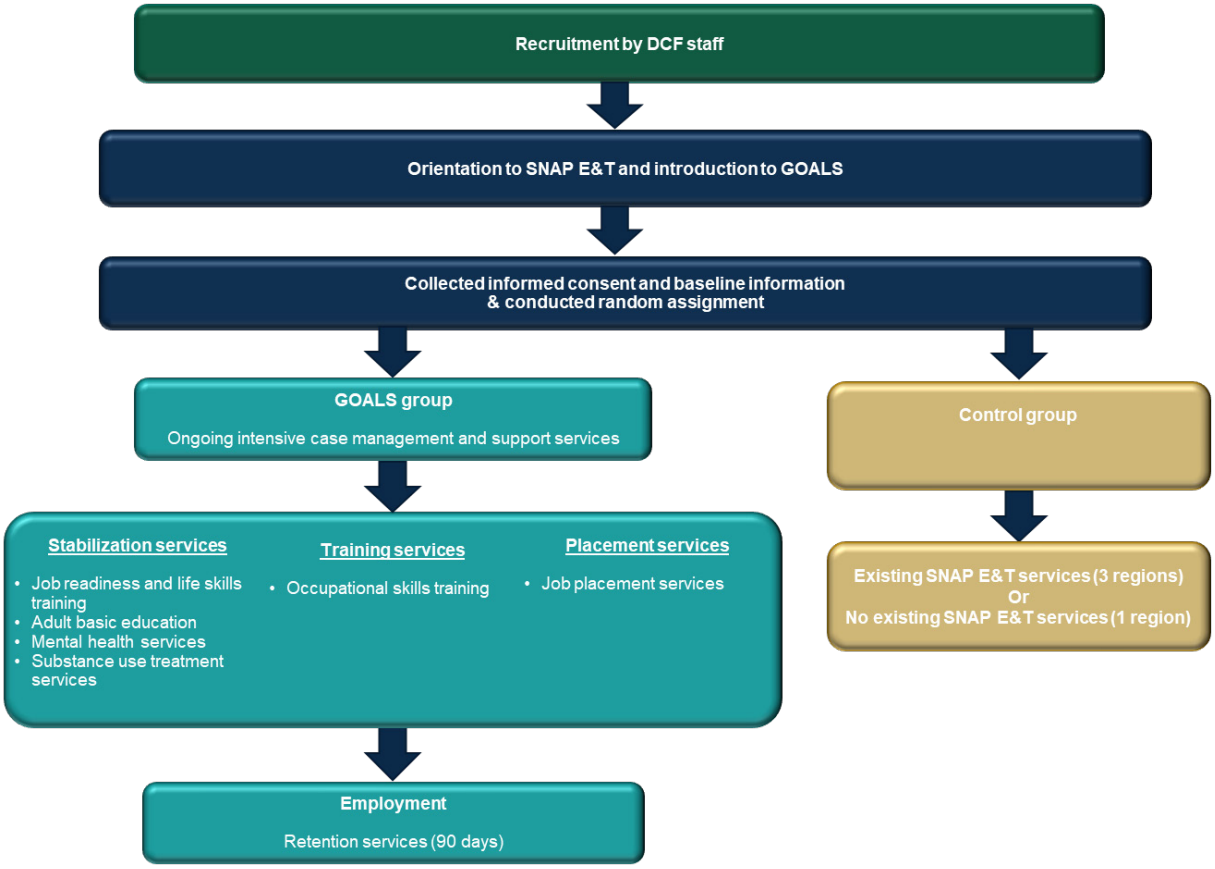
Note: A complete written description of Illinois' client flow and pilot pathways can be found in Chapter II, Section C of the Illinois Interim Evaluation Report.

IDHS = Illinois Department of Human Services

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

ISTEP = Individualized Services Training and Employment Plan

Appendix Table B.5. Kansas' client flow and pilot pathways

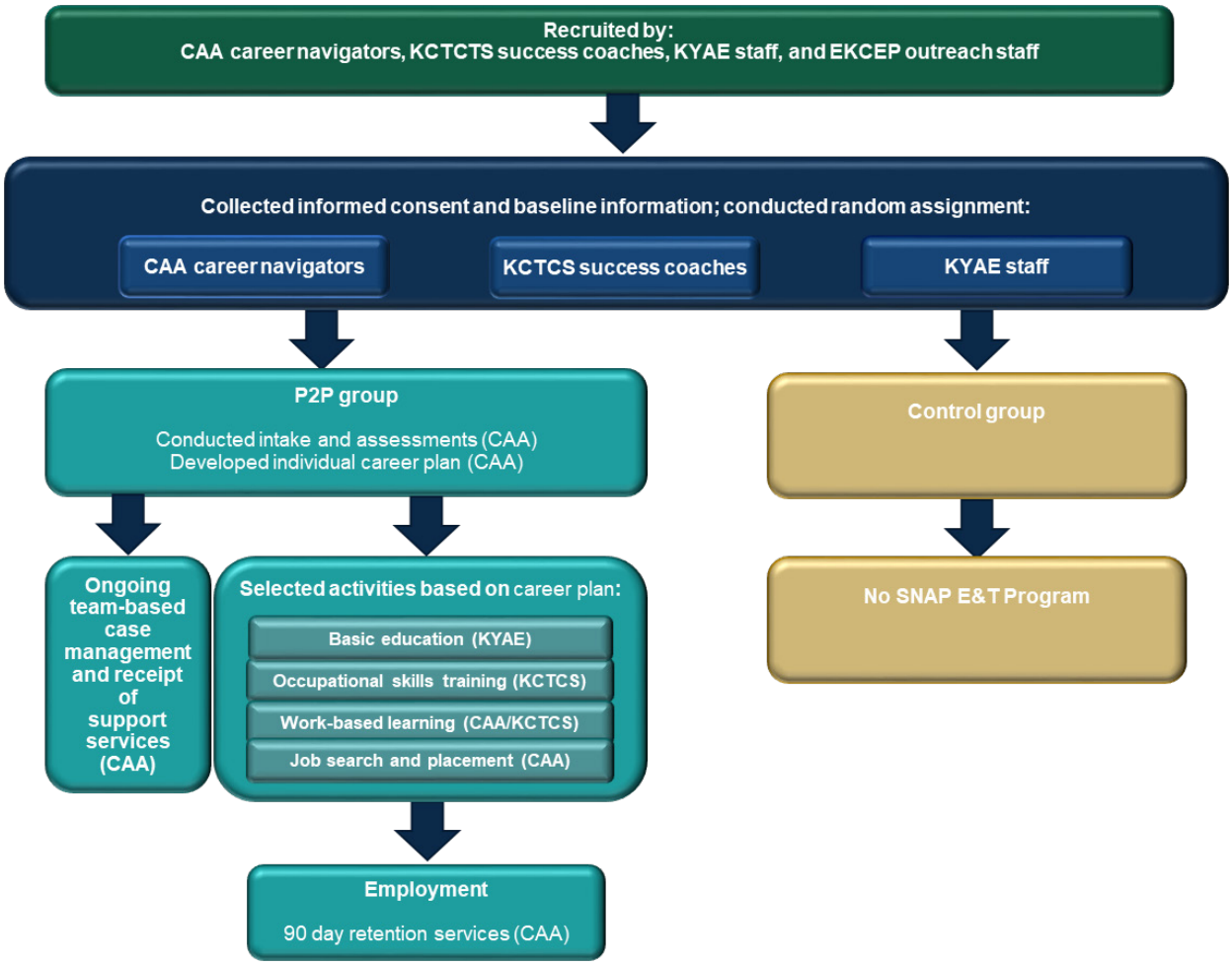


Note: A complete written description of Kansas' client flow and pilot pathways can be found in Chapter II, Section C of the Kansas Interim Evaluation Report.

DCF = Kansas Department for Children and Families

GOALS = Generating Opportunities to Attain Lifelong Success

Appendix Table B.6. Kentucky's client flow and pilot pathways



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

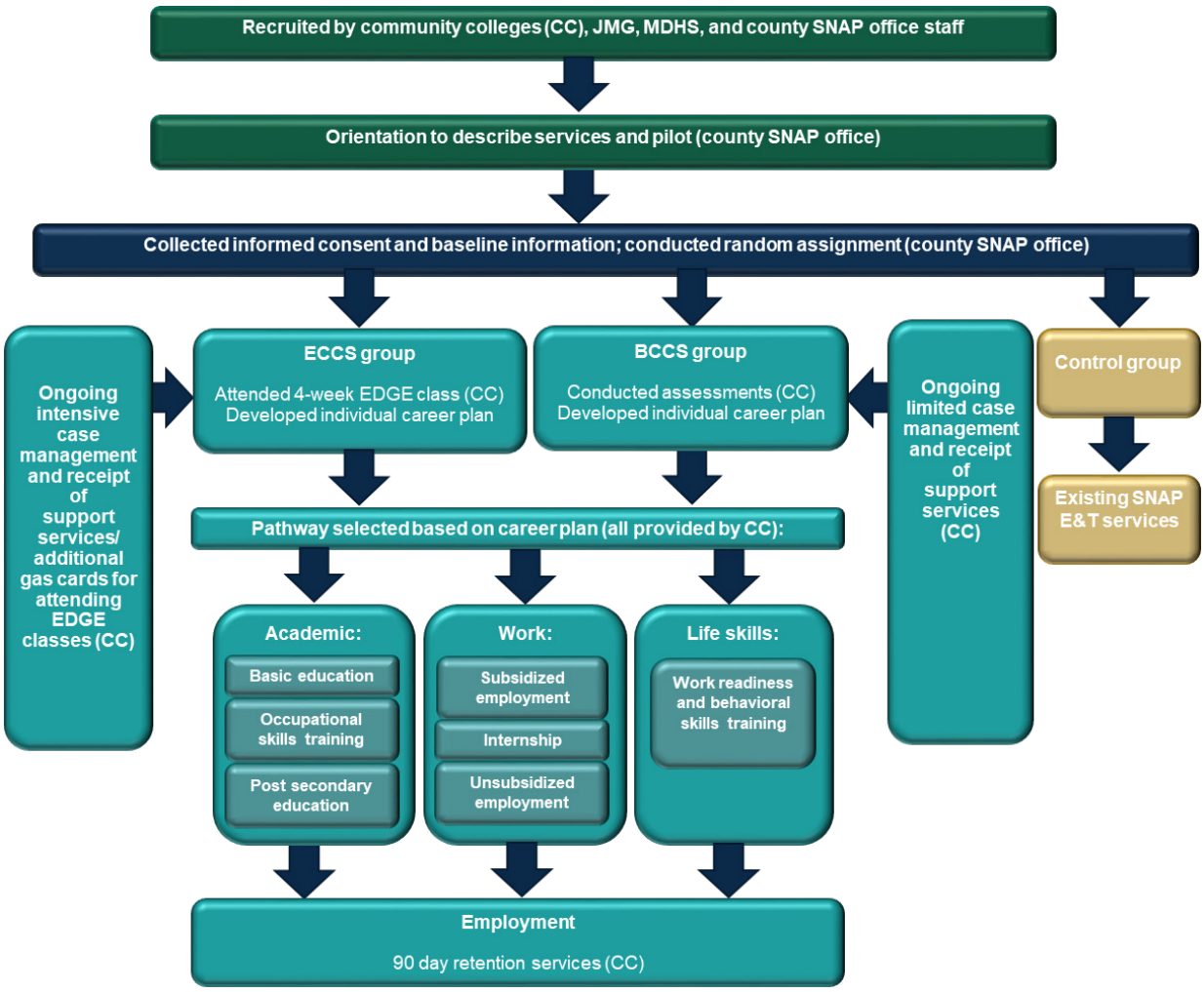
CAA = Community Action Agency

KCTCS = Kentucky Community and Technical College System

KYAE = Kentucky Adult Education

EKCEP = Eastern Kentucky Concentrated Employment Program

Appendix Table B.7. Mississippi's client flow and pilot pathways



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

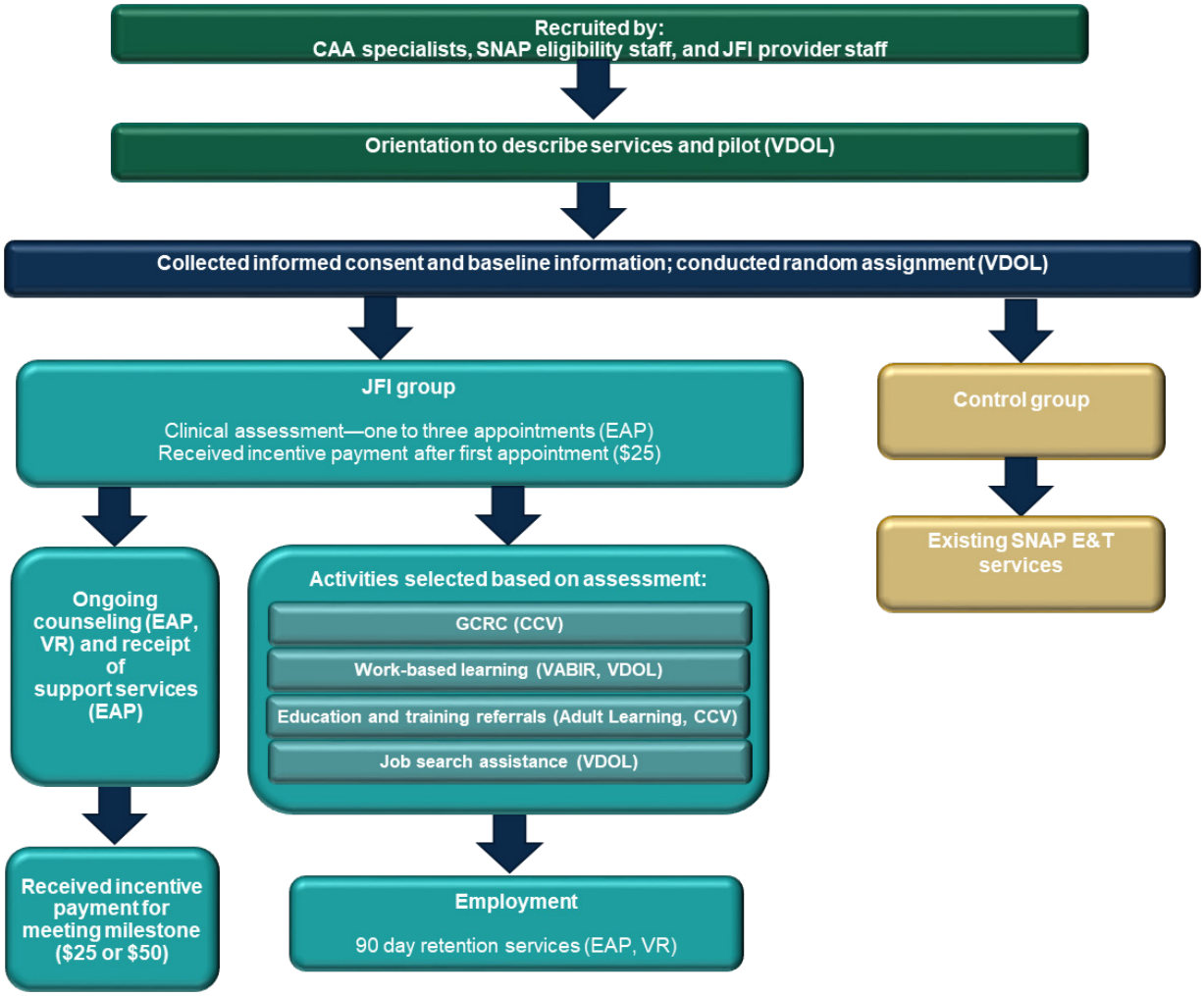
JMG = Jobs for Mississippi Graduates

MDHS = Mississippi Department of Human Services

ECCS = Enhanced Community College Services

BCCS = Basic Community College Services

Appendix Table B.8. Vermont's client flow and pilot pathways



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

JFI = Jobs for Independence

CAA = Community Action Agencies of Vermont

VDOL = Vermont Department of Labor

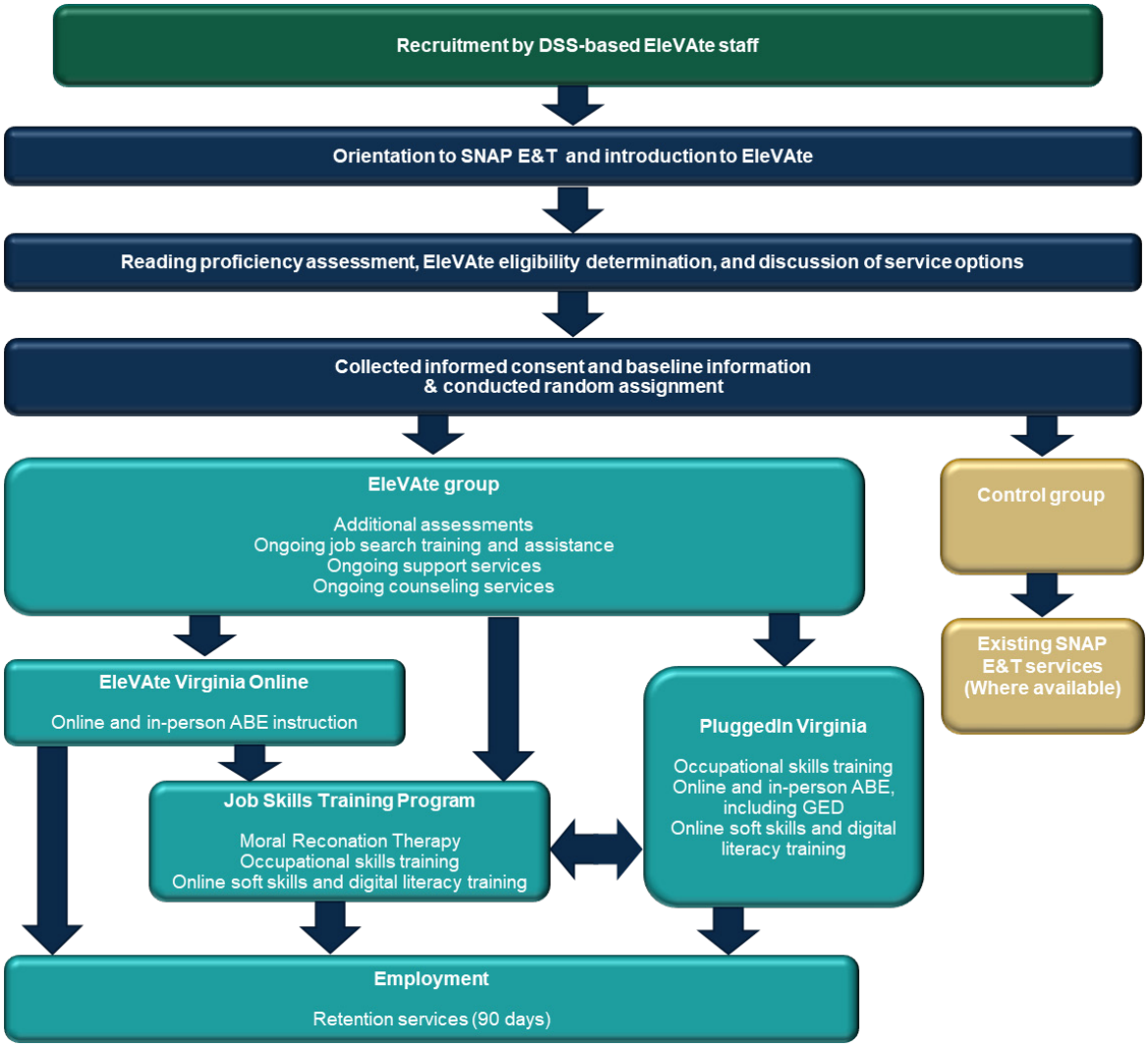
EAP = Employee Assistance Program

GCRC = Governor's Career Readiness Certificate

CCV = Community Colleges of Vermont

VR = Vermont Division of Vocational Rehabilitation

Appendix Table B.9. Virginia's client flow and pilot pathways



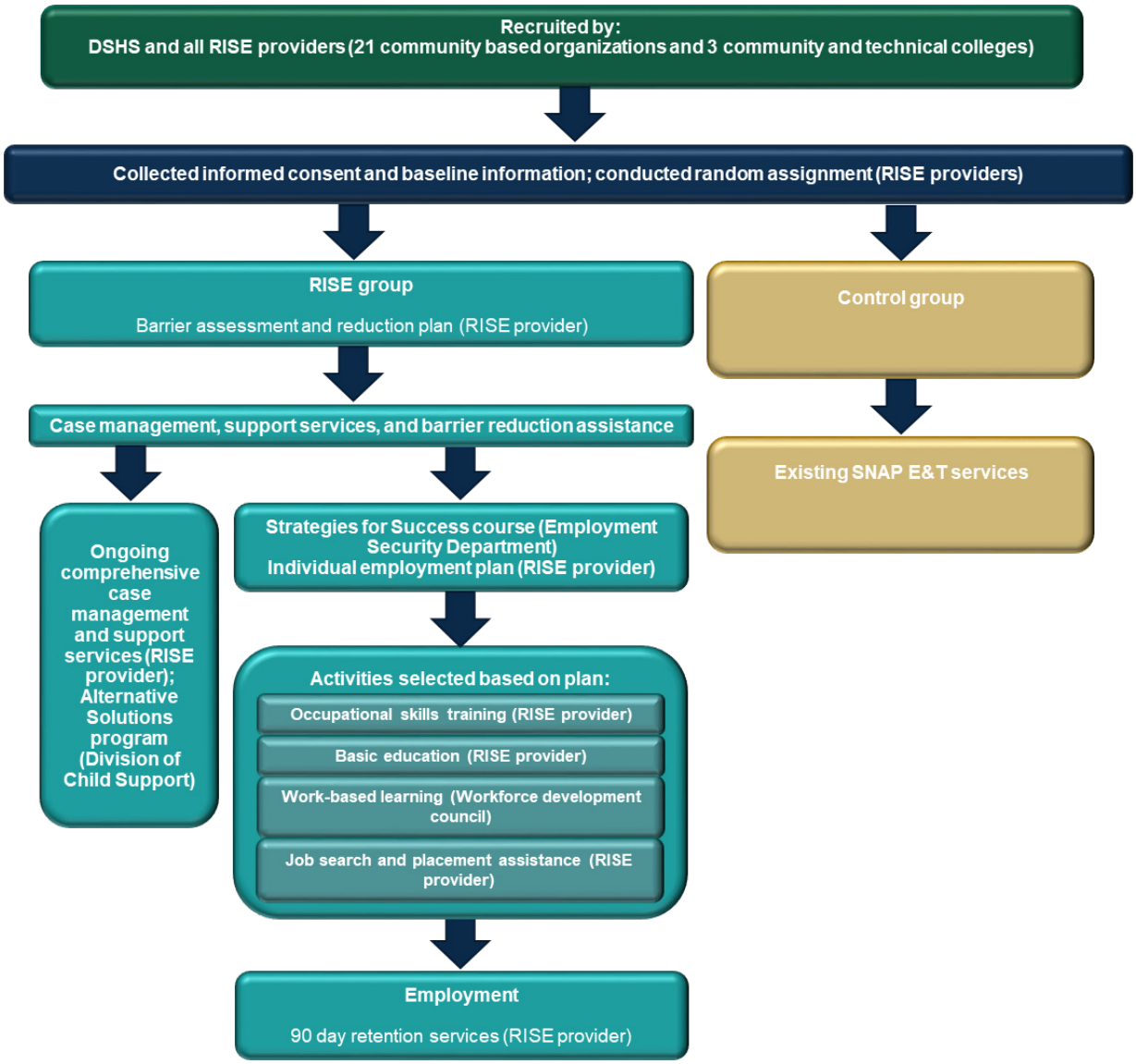
Note: A complete written description of Virginia's client flow and pilot pathways can be found in Chapter II, Section C of the Virginia Interim Evaluation Report.

DSS = Virginia Department of Social Services

ABE = Adult basic education

GED = General Education Diploma

Appendix Table B.10. Washington's client flow and pilot pathways



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

RISE = Resources to Initiate Successful Employment

DSHS = Washington Department of Social and Health Services

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

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
	Any activity[a]			Job search assistance or job search training activities			Education or occupational skills training		
CA (NS)	75.4	30.6	44.9***	65.3	16.5	48.9***	51.9	20.4	31.6***
CA (ES)	75.4	68.2	7.3**	65.3	59.0	6.4*	51.9	43.1	8.8**
DE	49.0	36.0	13.0***	41.8	27.8	14.0***	27.3	15.9	11.4***
GA	56.4	35.3	21.1***	50.0	27.6	22.4***	26.4	16.7	9.7***
IL	62.7	45.2	17.5***	53.8	37.5	16.3***	43.9	25.5	18.5***
KS	49.3	38.8	10.5***	37.5	27.5	10.1***	29.5	21.6	7.9***
KY	59.8	36.8	23.0***	26.2	16.5	9.7***	52.6	27.5	25.1***
MS (ECCS)	63.5	35.3	28.2***	49.6	25.4	24.2***	54.2	19.6	34.6***
MS (BCCS)	59.3	35.3	24.1***	30.6	25.4	5.3	47.8	19.6	28.4***
VA	67.4	42.6	24.8***	44.0	28.1	15.9***	61.6	30.9	30.7***
VT	53.8	43.6	10.2***	44.7	37.4	7.3**	30.4	20.2	10.1***
WA	60.7	49.3	11.4***	49.6	37.1	12.5***	44.9	30.4	14.4***

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

Note: CA (NS) and CA (ES) refer to the "no service" and "existing service" control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi. The correlation between (1) the difference in participation rates between the treatment and control groups and (2) the treatment group participation rate was 0.85 excluding the California ES control group, and 0.48 including the California ES group.

The correlation between (1) the difference in participation rates between the treatment and control groups and (2) the control group participation rate was -0.65 excluding the California ES control group, and -0.64 including the California ES group.

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

***Significantly different from zero at the .01 level, two-tailed test.

**Significantly different from zero at the .05 level, two-tailed test.

*Significantly different from zero at the .10 level, two-tailed test.

Appendix Table C.2. Rates of participation in specific types of activities, by pilot

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)	33.2	8.6	24.6***	28.9	12.1	16.9***
CA (ES)	33.2	23.7	9.4***	28.9	27.1	1.9
DE	17.0	8.0	9.0***	16.5	9.0	7.5***
GA	15.4	8.6	6.8***	14.9	8.6	6.3***
IL	29.0	16.2	12.8***	26.8	13.2	13.6***
KS	15.4	9.3	6.1***	18.7	10.7	8.1***
KY	24.8	12.5	12.3***	30.9	14.6	16.3***
MS (ECCS)	37.2	10.1	27.0***	34.0	10.2	23.7***
MS (BCCS)	26.8	10.1	17.0***	28.4	10.2	18.3***
VA	36.5	14.9	21.5***	43.1	19.6	23.6***
VT	20.0	10.6	9.4***	18.4	11.3	7.1***
WA	30.5	17.2	13.3***	23.5	17.3	6.2***
	Education			Work-based learning		
CA (NS)	26.7	8.8	18.0***	0.3	0.2	0.1
CA (ES)	26.7	16.7	10.1***	0.3	0.9	-0.6
DE	9.0	7.5	1.5	0.6	0.1	0.5***
GA	11.6	8.1	3.6***	0.0	0.1	0.0
IL	16.5	10.3	6.2***	0.2	0.1	0.1
KS	13.0	11.2	1.8	0.1	0.1	0.0
KY	25.8	15.1	10.7***	0.6	0.4	0.2
MS (ECCS)	27.2	9.8	17.4***	0.9	0.0	0.9**
MS (BCCS)	20.7	9.8	10.7***	0.1	0.0	0.1
VA	22.4	12.1	10.3***	0.2	0.0	0.2*
VT	13.8	8.2	5.7***	0.1	0.0	0.1
WA	18.0	11.0	7.0***	0.2	0.3	-0.1

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

Note: CA (NS) and CA (ES) refer to the "no service" and "existing service" control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi. Correlations exclude California (ES).

***Significantly different from zero at the .01 level, two-tailed test.

**Significantly different from zero at the .05 level, two-tailed test.

*Significantly different from zero at the .10 level, two-tailed test.

Appendix Table C.3. Rates of completion of education and training programs and activities and receipt of credentials, by pilot

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)	17.6	7.5	10.0***	34.4	37.2	-2.8
CA (ES)	17.6	16.3	1.1	34.4	35.3	-1.4
DE	14.5	7.7	6.8***	52.4	48.9	3.5
GA	12.5	9.2	3.2**	46.2	55.7	-9.5**
IL	25.5	13.1	12.5***	58.0	51.6	6.4*
KS	18.5	11.5	6.9***	65.4	54.8	10.7**
KY	22.2	12.0	10.3***	41.2	44.2	-3.1
MS (ECCS)	34.2	10.1	24.1***	62.5	50.4	12.1*
MS (BCCS)	20.1	10.1	10.2***	42.6	50.4	-8.4
VA	35.2	16.9	18.3***	57.4	55.2	2.2
VT	18.1	11.1	6.9***	58.1	55.7	2.4
WA	35.5	16.9	18.3***	57.4	55.2	2.2
	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)	8.5	4.1	4.4***	16.7	20.5	-3.8
CA (ES)	8.5	8.8	-0.5	16.7	19.5	-3.0
DE	7.2	3.3	3.9***	24.8	20.1	4.7
GA	6.0	3.3	2.7***	23.0	19.6	3.4
IL	16.1	6.2	10.0***	36.9	24.5	12.4***
KS	10.4	6.6	3.8***	38.7	31.4	7.3*
KY	11.6	6.1	5.5***	22.5	22.9	-0.4
MS (ECCS)	21.2	5.4	15.8***	38.3	26.7	11.6*
MS (BCCS)	13.0	5.4	7.8***	24.9	26.7	-1.9
VA	26.4	10.8	15.7***	43.3	35.2	8.0**
VT	7.0	5.3	1.7	20.0	26.6	-6.7
WA	26.4	10.8	15.7***	43.3	35.2	8.0***

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

Note: CA (NS) and CA (ES) refer to the "no service" and "existing service" control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi.

***Significantly different from zero at the .01 level, two-tailed test.

**Significantly different from zero at the .05 level, two-tailed test.

*Significantly different from zero at the .10 level, two-tailed test.

Appendix Table C.4. Receipt of case management and support services, by pilot

	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)	59.9	17.8	42.1***
CA (ES)	59.9	58.2	1.8
DE	49.5	30.9	18.6***
GA	47.6	24.8	22.7***
IL	47.0	34.6	12.4***
KS	54.4	44.8	9.6***
KY	41.6	24.9	16.8***
MS (ECCS)	30.2	27.0	3.2
MS (BCCS)	35.5	27.0	8.9***
VA	34.6	29.8	4.9**
VT	68.9	55.6	13.3***
WA	55.9	43.8	12.0***
Percentage that received any support service			
CA (NS)	49.3	28.9	20.4***
CA (ES)	49.3	49.2	0.1
DE	53.5	43.0	10.5***
GA	32.6	17.5	15.2***
IL	48.0	38.1	9.9***
KS	62.5	53.4	9.1***
KY	59.6	34.4	25.2***
MS (ECCS)	45.7	29.1	16.6***
MS (BCCS)	41.9	29.1	13.2***
VA	60.3	46.1	14.2***
VT	73.9	64.8	9.1***
WA	70.5	56.7	13.8***

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

Note: CA (NS) and CA (ES) refer to the “no service” and “existing service” control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi.

Appendix Table C.4. Receipt of case management and support services, by pilot *(continued)*

The correlation between (1) the difference in rates of receipt of case management between the treatment and control groups and (2) the treatment group rate of receipt of case management was 0.51, excluding the California ES control group, and 0.36 including the California ES group.

The correlation between (1) the difference in rates of receipt of case management between the treatment and control groups and (2) the control group rate of receipt of case management was -0.42 excluding the California ES control group, and -0.52 including the California ES group.

The correlation between (1) the difference in rates of receipt of support services between the treatment and control groups and (2) the treatment group rate of receipt of support services was -0.19, excluding the California ES control group, and -0.07 including the California ES group.

The correlation between (1) the difference in rates of receipt of support services between the treatment and control groups and (2) the control group rate of receipt of support services was –0.52 excluding the California ES control group, and -0.51 including the California ES group.

***Significantly different from zero at the .01 level, two-tailed test.

**Significantly different from zero at the .05 level, two-tailed test.

*Significantly different from zero at the .10 level, two-tailed test.

Appendix Table D.1. Employment and SNAP participation rates in Quarter 4, by pilot

Pilot	Employment rate based on UI wage records			Employment rate based on survey data			SNAP participation in Quarter 4		
	Treatment group	Control group	Treatment –control difference	Treatment group	Control group	Treatment –control difference	Treatment group	Control group	Treatment –control difference
CA (NS)	50.2	48.9	1.3	47.8	43.6	4.2*	80.1	80.1	0.0
CA (ES)	50.2	48.7	1.6	47.8	44.7	3.0	80.1	80.3	-0.2
DE	44.7	48.2	-3.5*	54.9	56.0	-1.1	56.9	53.3	3.6***
GA	52.2	50.1	2.1	50.4	52.2	-1.8	48.4	46.7	1.7
IL	47.5	48.1	-0.6	44.7	43.9	0.8	55.6	58.8	-3.2**
KS	59.5	55.2	4.3***	60.8	58.3	2.4	61.1	59.4	1.8
KY	45.8	42.2	3.6*	44.0	40.5	3.4	78.8	76.5	2.3
MS (ECCS)	43.3	43.9	-0.6	47.4	48.6	-1.2	48.5	39.4	9.0***
MS (BCCS)	44.1	43.9	0.3	48.9	48.6	0.8	48.2	39.4	8.8***
VA	51.4	55.8	-4.4**	49.7	52.8	-3.1	74.1	70.0	4.1***
VA	43.9	45.2	-1.3	49.3	48.3	1.0	64.0	63.9	0.1
WA	45.2	44.3	0.9	48.6	47.8	0.8	77.1	74.2	2.9**

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

Note: CA (NS) and CA (ES) refer to the "no service" and "existing service" control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi.

***Significantly different from zero at the .01 level, two-tailed test.

**Significantly different from zero at the .05 level, two-tailed test.

*Significantly different from zero at the .10 level, two-tailed test.

Appendix Table D.2. Quarterly earnings and food security status, by pilot

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)	2,104	1,917	187**	2,261	1,893	369***
CA (ES)	2,104	2,007	97	2,261	2,017	239
DE	1,773	1,819	-47	2,799	2,987	-188
GA	2,131	2,032	98	2,554	2,627	-73
IL	1,800	1,765	34	2,151	2,063	88
KS	2,167	1,979	189**	2,978	2,862	116
KY	1,447	1,469	-22	1,632	1,633	-1
MS (ECCS)	1,521	1,301	220	2,176	2,151	24
MS (BCCS)	1,394	1,301	96	2,082	2,151	-56
VA	1,832	2,059	-226**	2,237	2,325	-88
VT	1,774	1,859	-84	2,483	2,426	-88
WA	1,837	1,954	-117	2,657	2,911	-255
	Living in a household that is food insecure			Living in a household with very low food security		
CA (NS)	45.9	52.0	-6.1**	28.6	30.5	-1.9
CA (ES)	45.9	47.5	-1.6	28.6	25.5	3.1
DE	57.0	55.2	1.7	37.2	35.9	1.3
GA	57.8	59.0	-1.2	39.2	39.2	0.0
IL	57.3	60.1	-2.8	35.3	40.6	-5.3**
KS	58.6	59.6	-1.0	37.4	38.6	-1.2
KY	46.8	51.3	-4.5	30.6	32.0	-1.5
MS (ECCS)	61.9	64.9	-2.9	41.9	46.7	-4.8
MS (BCCS)	53.9	64.9	-11.2***	37.5	46.7	-9.3**
VA	51.4	52.7	-1.4	29.4	32.0	-2.6
VT	62.0	60.6	1.4	41.7	45.1	-3.4
WA	58.9	59.2	-0.3	40.7	38.7	2.0

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

Note: CA (NS) and CA (ES) refer to the "no service" and "existing service" control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi.

***Significantly different from zero at the .01 level, two-tailed test.

**Significantly different from zero at the .05 level, two-tailed test.

*Significantly different from zero at the .10 level, two-tailed test.

Appendix Table D.3. Alignment of impacts on earnings, employment, and SNAP participation across pilots

Earnings and employment impacts	SNAP participation impacts: No change	Positive some quarters	Positive all quarters	Negative in some quarters
Earnings for the treatment group were lower than those for the control group in early quarters, but earnings for the treatment group grew over time, resulting in no statistically significant difference between research groups in earnings in Quarter 4.				
Employment rate was higher for treatment group than control group in Quarter 4				
Employment rate was similar for treatment group and control groups in Quarter 4 (GA, IL)		GA (1,2)		IL (3,4)
Employment rate was lower for treatment group than control group in Quarter 4 (DE)			DE (1,2,3,4)	
Earnings were similar for treatment and control groups in early quarters, but earnings for the treatment group grew faster over time, resulting in statistically significantly higher earnings for the treatment group than the control group in Quarter 4.				
Employment rate was higher for treatment group than control group in Quarter 4 (CA, KS)	CA	KS (1,2)		
Employment rate was similar for treatment group and control groups in Quarter 4				
Employment rate was lower for treatment group than control group in Quarter 4				
Earnings were similar for treatment and control groups in all quarters.				
Employment rate was higher for treatment group than control group in Quarter 4 (KY)		KY (2,3)		
Employment rate was similar for treatment group and control groups in Quarter 4 (MS, VT, WA)	VT	WA (2,3,4)	MS (1,2,3,4)	
Employment rate was lower for treatment group than control group in Quarter 4				
Earnings for the treatment group were lower than those for the control group in all four quarters.				
Employment rate was higher for treatment group than control group in Quarter 4				
Employment rate was similar for treatment group and control groups in Quarter 4				
Employment rate was lower for treatment group than control group in Quarter 4 (VA)			VA (1,2,3,4)	

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

Note: CA (NS) and CA (ES) refer to the “no service” and “existing service” control groups in California, respectively. MS (ECCS) and MS (BCCS) refer to the ECCS and BCCS treatment groups in Mississippi. Numbers in parentheses represent quarters in which SNAP participation rates were higher or lower for the treatment group relative to the control group. Categorization of pilots by earnings based on UI data.