Lessons from SSA Demonstrations for Disability Policy and Future Research

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Overview

Over the past several decades, the Social Security Administration has tested many new policies and programs to improve work outcomes for Social Security Disability Insurance beneficiaries and Supplemental Security Income recipients. These demonstrations have covered most aspects of the programs and their populations. The demonstrations examined family supports, informational notices, changes to benefit rules, and a variety of employment services and program waivers.

A "State of the Science Meeting," sponsored by the Social Security Administration and held on June 15, 2021, commissioned papers and discussion by experts to review the findings and implications of those demonstrations.

A subsequent volume—*Lessons from SSA Demonstrations for Disability Policy and Future Research*—collects the papers and discussion from that meeting to synthesize lessons about which policies, programs, and other operational decisions could provide effective supports for disability beneficiaries and recipients who want to work. This PDF is a selection from that published volume. References from the full volume are provided.

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Chapter 8

Benefits Counseling and Case Management

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The Social Security Administration (SSA) provides income support for older adults, individuals with disabilities, and families with low incomes through the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. SSI is a means-tested program that is available to older adults, working-age adults with disabilities, and children with disabilities based on eligibility criteria related to disability, income, and assets. SSDI is a social insurance program and provides cash benefits to workers with disabilities and certain members of their family.[1] Both SSI and SSDI also offer entitlement to health insurance. SSI confers Medicaid eligibility for recipients, and SSDI beneficiaries become entitled to Medicare after receiving SSDI for 24 months.

These income support and safety net programs are an essential lifeline for millions of Americans who are unable to work and maintain economic self-sufficiency. For example, in 2019, SSI provided more than $52 billion in income support for 6.9 million individuals with disabilities (SSA 2019c); SSDI provided more than $11 billion in income support to 9.2 million working-age adults in 2018 (SSA 2019d). For individuals who are entering or re-entering the workforce, case management and benefits counseling services can assist in navigating the complex landscape of programs and policies that support work activity. This chapter will examine the impact of benefits counseling and case management services offered in the context of SSA demonstrations.

HISTORY, POLICY SETTING, AND CURRENT PROGRAM RULES

The Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) was established to remove barriers to employment and to provide health care and employment services to SSDI beneficiaries and SSI recipients. The legislation recognized the need for benefits planning and assistance as a core service needed by individuals with disabilities who received SSI and/or SSDI. SSA established the Benefits Planning, Assistance, and Outreach (BPAO) program subsequent to the Ticket Act by entering into 116 cooperative agreements with community organizations across the nation (Livermore and Prenovitz 2010). By the end of 2001, all states had at least one entity that received funding from SSA to implement a BPAO program.

[1] Title II of the Social Security Act provides cash payments through SSDI to individuals who are younger than age 65, have earned sufficient work credits, and meet the definition of disabled.

The BPAO system was designed to assist SSI recipients and SSDI beneficiaries in maneuvering a complex set of public benefits programs, as well as to minimize disincentives and barriers to preparing for, retaining, or advancing in employment. Benefits specialists received intensive training on work incentives programs and provided services to individuals in person or over the phone. Under the BPAO, benefits specialists were instructed not to direct or influence beneficiaries and recipients regarding their employment-related decisions. Rather, BPAO counselors focused their services on education and sharing of accurate information in one or two sessions (Livermore and Prenovitz 2010; O'Day et al. 2009). In general, BPAO had mixed results in supporting the goals of the Ticket to Work program, which is to assist SSDI beneficiaries and SSI recipients in their transition to long-term employment and reduce their reliance on benefits. Findings from customer satisfaction surveys (Bruyere et al. 2007) suggest that BPAO was successful in providing accurate information to beneficiaries and recipients. However, findings from the State Partnership Initiative (SPI) suggested that benefits counseling may reduce earnings (O'Day et al. 2009). Subsequently, SSA determined that a greater emphasis on employment and in-depth services was needed to achieve the program's goals (O'Day et al. 2009).

In 2006, SSA's program priorities shifted from providing basic information about work incentives to providing long-term employment supports coupled with case management (O'Day et al. 2009). The Work Incentives Planning and Assistance (WIPA) program grew out of the BPAO program and was established in 2006 with the goal of increasing community partnerships, with a renewed focus on achieving employment outcomes. SSA recognized that SSDI beneficiaries and SSI recipients needed intensive services (rather than one or two the sessions that was typical in BPAO) to fully understand and use work incentives (O'Day et al. 2009). The overarching purpose of WIPA is to provide accurate information and counseling about the impact of work-related income on benefits and supplemental income programs. WIPA programs deliver services in four broad categories: work incentives planning; work incentives assistance; work incentives education, marketing, and recruitment of beneficiaries and recipients; and outreach services (O'Day et al. 2009).

WIPA is implemented through community work incentives coordinators (CWICs) whose role is to provide ongoing, comprehensive work incentives monitoring and management and to help SSDI beneficiaries and SSI recipients develop long-term work plans. CWICs provide both information and referrals and more intensive counseling services about benefits and employment. CWICs provide information tailored to beneficiaries' and recipients' needs and employment goals including any health insurance protections and work incentives that beneficiaries and recipients could qualify for. CWICs also verify eligibility requirements and educate beneficiaries and recipients about requirements to report wages and other income or change in work activity, thus helping them navigate a complex system of supports and services.

Eligibility for WIPA services is based on age (14 and older) and receipt of SSI, SSDI, disabled widower benefits, childhood disability benefits, or Medicare coverage based on disability status. WIPA services are prioritized for SSDI beneficiaries and SSI recipients who are working full-time or part-time, in the process of interviewing for work, or US military veterans who are working or seeking employment. WIPA services are also available to transition-aged youth (ages 14–24) and US veterans who are considering working.

WIPA counselors can be reached via a referral from a help line or by contacting WIPA offices directly. Once contact has been established, WIPA counselors work with SSDI beneficiaries and SSI recipients to gather information on current benefits and goals for employment. The CWIC verifies current benefits and over several sessions provides education and counseling on how work income could affect federal and state benefits, health insurance, and work supports. A written Benefits Summary and Analysis (BS&A) is provided to beneficiaries and recipients summarizing their current benefits and future goals for employment. Counselors who provide WIPA services are trained and certified through an SSA-funded Technical Assistance center. WIPA programs operate in close collaboration with several other programs and agencies, such as Ticket to Work, the Protection and Advocacy to Beneficiaries of Social Security (PABSS) grant program, Employment Networks, and Vocational Rehabilitation (VR) agencies.

WIPA programs facilitate the use of several work incentives such as impairment-related work expenses (IRWEs), Plan to Achieve Self-Support, Trial Work Period, and so on. IRWEs allow SSDI beneficiaries and SSI recipients to deduct the cost of certain impairment-related expenses from their earnings. PASS allows SSI recipients to set aside income and resources that will help them achieve self-sufficiency with the amount set aside not counting toward determining SSI eligibility or payments. Trial Work Period allows SSDI beneficiaries at least nine months to test their ability to work. During the Trial Work Period, SSDI beneficiaries will continue receiving benefits regardless of their income as long as work activity is being reported (SSA 2020e).[2]

It should be noted that SSA has generally not provided case management services to SSDI beneficiaries and SSI recipients outside of demonstration programs. However, SSA has included case management in many of its demonstrations, such as the Mental Health Treatment Study (MHTS) and SPI. In these demonstrations, the overarching purpose of case management was to provide information and referral to vocational assessments, employment services, and if needed, work incentives planning. Additionally, case management may be provided by Employment Networks or Vocational Rehabilitation agencies, funded or contracted by SSA.

The following section describes the theoretical frameworks for understanding benefits counseling and case management, followed by a review of SSA

[2] A more detailed description of all work incentives is available in the *Red Book* (SSA 2020e).

demonstrations and empirical research on benefits counseling and case management. Last is a summary of knowledge gained and research/policy recommendations for SSA.

THEORY AND IMPLICATIONS FROM THEORY

SSDI beneficiaries and SSI recipients experience systemic, structural, and personal barriers in seeking and retaining employment. Income support programs such as SSI and SSDI support a beneficiary's and recipient's ability to meet basic needs. However, the process of applying to and getting approved for SSI or SSDI benefits can be a long and arduous one. Because the approval process for SSI or SSDI requires demonstrated inability to work, some beneficiaries and recipients internalize this message and assume that they are unable to return to work even as their underlying condition stabilizes or improves (Miller and O'Mara 2003; Peikes et al. 2005). Yet other beneficiaries and recipients could desire to return to work but might not fully comprehend how their return affects their income, disability, and health benefits. The broad goal of *benefits counseling* is to provide information and counseling support so that SSDI beneficiaries and SSI recipients reach their employment goals and increase their economic self-sufficiency. Benefits counseling unfolds through the process of assessing and understanding the beneficiary's and recipient's employment goals, identifying viable options, sharing accurate information, and tracking and managing benefits (Delin, Hartman, and Sell 2012).

Benefits counseling can address the employment gap by providing in-depth analysis of pros and cons, step-by-step guidance, and follow-up monitoring of how well SSDI beneficiaries and SSI recipients understand and use the current programs offered by SSA. *Case management* involves collaborative assessment, planning, and mobilization of resources and care coordination. Within the context of SSA programs, case management is broader in scope than benefits counseling and can involve connecting beneficiaries and recipients with employment, housing, health care, and financial literacy resources.

Framework for Understanding Benefits Counseling and Case Management

Kregel and O'Mara (2011) describe four stages along an "employment continuum" that SSDI beneficiaries and SSI recipients go through while seeking employment. The first, *contemplative stage* is when beneficiaries and recipients are thinking about working but they generally lack any concrete vocational goals. In the second, *preparatory stage* beneficiaries and recipients have made an active choice to pursue employment goals and may have taken steps to work toward these goals. In the third, *job search stage* beneficiaries and recipients solidify their efforts by seeking employment support services, applying for jobs, interviewing, and so on. In the final, *employment stage* beneficiaries and recipients are successfully employed. Though some SSDI beneficiaries and SSI recipients remain in this last stage for a prolonged

period, others can experience challenges to sustaining work and consider leaving their jobs or scaling back. Kregel and O'Mara's conceptualization of an employment continuum closely aligns with the transtheoretical (or stages of change) model (DiClemente at al. 1991) that describes a cyclical process individuals go through when engaging in a new behavior.

Benefits Counseling

Golden et al. (2005) define benefits counseling as

> a set of benefits counseling strategies, services and supports that seek to promote work preparation, attachment, and advancement focusing on the enhancement of self-sufficiency and independence of Social Security Administration beneficiaries and recipients with disabilities through informed choice, which may result in decreased reliance on public benefit programs and increased financial well-being. (xvi)

The process of benefits counseling begins with the beneficiary or recipient seeking services. The counselor gathers information about the beneficiary's or recipient's goals, current benefits, and work situation. The counselor verifies the benefits and provides referrals to programs that may support the beneficiary's or recipient's work attempt or financial situation. The counselor educates the beneficiary or recipient about the effect of earnings on benefits, documents the counseling, and provides follow-up services as needed.

Benefits counseling programs were developed within the context of income support programs such as SSI or Temporary Assistance for Needy Families specifically to provide accurate information about complex benefits and work incentives to vulnerable populations that depend on them. Because they were developed for pragmatic reasons, the theoretical or conceptual foundation of benefits counseling programs is unclear.[3] Nevertheless, benefits counseling programs offered by SSA are somewhat aligned with well-established principles of employment or career counseling—such as creating a therapeutic alliance, being person centered, and the like. Two theoretical frameworks that can be used to understand and evaluate benefits counseling programs are *cognitive information processing theory* and the *solutions-focused approach*. Cognitive information processing theory suggests that making career and employment choices involves knowledge (understanding information) and feelings (self-awareness, motivation). One common aspect of benefits counseling and cognitive information processing theory is that both emphasize career readiness and the importance of case management services to assist an individual to attain their employment goals (Sampson et al. 2004).

[3] Golden et al. (2000) retrospectively proposed a theoretical framework for benefits planning and advisement after the Ticket to Work program was established.

Bezanson (2004) described a solutions-focused approach to employment and benefits counseling. Counselors using a solutions-focused approach help their clients develop an alternate vision for their future; one that allows them to acknowledge their problems and not circumvent the same. It is a goal-directed, future-oriented approach where the goal is to find solutions to problems rather than examine their causes (Trepper et al. 2006; Proudlock and Wellman 2011). Solutions-focused counselors take the role of an active listener and facilitator rather than an expert who is sharing their opinion. Through a series of open-ended questions, positive affirmations, and solutions-focused discussion, the counselor leads clients to uncover their motivation and develop realistic employment-related goals. Some commonalities between SSA benefits counseling approaches and the solutions-focused approach are the acknowledgement of reality (i.e., potential loss of benefits and health care) and direct action to address this potential loss by directing beneficiaries or recipient to other programs or employment to replace essential income and supports and improve beneficiaries' and recipients' economic position through work.

The solutions-focused approach is distinct from motivational interviewing or cognitive behavioral therapy. *Motivational interviewing* is a counseling practice that addresses ambivalent thinking and internal motivation to implement change in behavior. *Cognitive behavioral therapy* is a type of psychotherapy that helps individuals identify automatic negative thought processes that can influence their behavior and learn coping strategies to break away from the thought patterns. Although a solutions-focused approach has not been tested for its efficacy in benefits counseling, the model offers a framework to address barriers in a proactive manner.

Case Management

Case management is a complement to benefits counseling that integrates medical or social care services that address physical and social functioning with the goal of maximizing the individual's ability to recover and thrive in the community (Kanter 1989). The National Association of Social Workers (2013) defines case management as "a process to plan, seek, advocate for, and monitor services from different social services or health care organizations and staff on behalf of a client." In practical terms, case management is the mobilization, integration, and coordination of care in low-resource environments to maximize function (Ziguras and Stuart 2000).

Solomon (1992) described four distinct approaches to case management: assertive community treatment (ACT), strengths-based case management, rehabilitation case management, and generalist case management. ACT is a model provided in community settings rather than hospital or institutional settings. Clients have access to services at any time through on-call case managers, and the nature of services provided is individualized and intensive. The strengths-based case management has a strong theoretical foundation in positive psychology to leverage a person's strengths and

informal support networks to achieve desired outcomes.[4] Strengths-based approaches along with person-centered approaches, which are commonly used for youth case management, can especially be helpful in leveraging the strengths and motivation of beneficiaries and recipients to return to work. Rather than focusing on limitations, a strengths-based model focuses on capacities, skills, and abilities, regarding the individual as an active actor and co-director, rather than a passive recipient. Rehabilitation case management has the specific goal of service coordination among rehabilitation and medical professionals and case managers.

Regardless of the type of case management, some common denominators are flexibility, resourcefulness, creating structural supports, and building trust and rapport with clients.

REVIEW OF EMPIRICAL FINDINGS FROM SSA DEMONSTRATIONS

Benefits counseling and case management are critical components of SSA's demonstrations to help SSDI beneficiaries and SSI recipients navigate health care and employment supports. This section details specific SSA demonstrations that included substantial case management and benefits counseling components and analyzes outcomes attributed to those components.[5]

Benefit Offset National Demonstration (BOND)

BOND was created in response to a congressional mandate that SSA explore ways to increase the incentives for SSDI beneficiaries to return to work and subsequently decrease their reliance on SSDI benefits. BOND included two stages; Stage 1 tested the effect of a benefit offset for all beneficiaries; Stage 2 was implemented with a select group of volunteer and recruited beneficiaries to examine the impact of the offset and specific enhancements to counseling services. Beneficiaries were randomly assigned to one of three groups; (1) offset plus work incentives counseling (WIC); (2) offset plus enhanced work incentives counseling (EWIC); and (3) current-law rules, including benefits counseling (control). WIC was designed to be comparable to the WIPA services except that it was geared to address special provisions under BOND. EWIC included all services under WIC plus vocational skill and interest assessments, assistance, and support necessary for the beneficiaries to find and sustain employment. Findings discussed in this section are drawn from process and impact reports of BOND (Derr et al. 2015; Geyer et al. 2018; Gubits et al. 2018a/b).

Ten BOND sites were selected for the demonstration based on their geographic location, staffing, availability of employment services, and non-BOND benefits

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[4] Positive psychology is the study of positive subjective experiences, emotions, traits, and strengths that enable individuals to thrive and flourish, unlike traditional psychology, which focuses on distorted thoughts and behaviors.

[5] SSA demonstrations that included benefits counseling and/or case management as a minor component are not discussed in this chapter.

counseling. BOND sites followed either a dispersed or dedicated staffing model for providing benefits counseling services. In the dispersed model, multiple staff devoted a portion of their time to provide BOND benefits counseling. In the dedicated model, all staff time was devoted to providing BOND counseling (Derr et al. 2015). The staffing model had implications for the nature of the counseling provided, as discussed at the end of this section. The following discussion will be limited to the impact of benefits counseling offered through Stage 2 of BOND.

As intended, there were major differences in the quantity and nature of counseling services provided to Stage 2 BOND beneficiaries. Treatment group 1 (WIC) and control group beneficiaries typically received information and referral services and basic information about work supports and incentives. Counselors for treatment group 2 (EWIC) were expected to proactively communicate with beneficiaries frequently, a process called "follow-up and follow-along services." WIC staff prepared written BS&A plans documenting how earnings may impact work incentives. EWIC staff developed BS&As, Employment Services Plans documenting barriers to employment, specific plans to overcome the same, and referrals to VR agencies or Employment Networks for additional evaluation and support (Gubits et al. 2018a/b). In general, beneficiaries in the EWIC group were more likely to have BS&As. Specifically, 65 percent of employed beneficiaries receiving EWIC had a BS&A, compared to 21 percent of beneficiaries in WIC. Similarly, beneficiaries who were looking for work and not in the labor force were more likely to have BS&As if they were in the EWIC group (Gubits et al. 2018a/b). EWIC counselors also reported spending a substantial amount of time on post-entitlement services such as completing SSA 820/821 forms, monitoring continuing disability review progress, and preparing Annual Earnings Estimates. In contrast, WIC counselors were required simply to respond to beneficiaries' inquiries (Derr et al. 2015).

There were also fundamental differences in how beneficiaries engaged with the WIC and EWIC counselors. It was typical for WIC counselors to provide a one-time information and referral service or to engage in brief contacts. Subsequently, the caseload for WIC counselors was much higher than EWIC counselors. On average, the EWIC caseload was about half the WIC caseload. As of January 2014, WIC caseloads per full-time-equivalent counselor ranged from 119 to 222 beneficiaries, whereas EWIC caseloads per full-time-equivalent ranged from 76 to 116 beneficiaries. Beneficiaries receiving EWIC were consistently referred for outside support and services. The largest number of referrals were seen among beneficiaries who were looking for work. More than half of the beneficiaries who already were employed when they joined the study ("at baseline") also received referral services, likely related to retaining or seeking different employment opportunities. As expected, once referrals were made, EWIC counselors followed up with the referral source to close any gaps in service delivery.

Ten performance benchmarks[6] for each BOND site were established prior to BOND implementation. The benchmark for initial contact and assessment was 100-90 percent; 80 percent for service coordination and pre-employment skills training; and 33 percent for WIC. It should be noted that performance reports for EWIC counselors were based on the number of engaged beneficiaries. All EWIC sites met performance benchmarks with one exception ("any contact last month"). EWIC sites well exceeded other benchmarks related to conducting needs assessments, skills assessments, service coordination, pre-employment skills training for those who needed it, and information and referral assessment.

In summary, there were considerable differences in the nature and impact of services provided through WIC and EWIC. These differences were compounded by extrinsic factors such as the caseload of counselors at each site and program, geographic factors, economic factors, and demonstration design. For example, because WIC enrollment (and the WIC caseload) was lower than expected, WIC staff were able to provide services that were more extensive than planned. This difference was more noticeable because EWIC enrollment exceeded expectations, thereby increasing the caseload for EWIC counselors. Geographic location of sites and staffing models could have also been confounding factors in determining the effectiveness of the services. Sites in rural locations likely had fewer employment-related services available near them, making it challenging for beneficiaries to receive essential support services (Derr et al. 2015).

Finally, the staffing model could have influenced the quality of services. In sites where a dispersed model was used, there was some anecdotal evidence of confusion between the different treatment options because staff in these sites provided BOND services infrequently. According to the findings from the Stage 2 early assessment report, several counselors noted that they were initially unfamiliar with how BOND offset worked and therefore were not able to provide accurate information to their clients (Derr et al. 2015). This lack on the part of BOND staff could have negatively affected program outcomes.

Preliminary evidence from BOND focus groups suggests that benefits counselors adapted to providing services over the telephone and that it was possible to maintain effective communication between counselors and beneficiaries that way. At the end of Stage 2, EWIC beneficiaries were more engaged with counselors, used more information and referral services, and interacted with their counselors more. Ultimately, there was no difference in earnings outcomes between the groups receiving WIC and EWIC services (Gubits et al. 2018a/b).

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[6] Performance benchmarks established for engaged beneficiaries in the BOND EWIC group: any contact last month, barriers and needs assessment, skills assessment, Employment Services Plan, service coordination among those with documented need, pre-employment skills training, information and referral assessment, baseline assessment, BS&A, and Work Incentives Plan.

Promoting Opportunity Demonstration (POD)

POD began in 2018 and ended in June 2021 (Mamun et al. 2021). Its purpose was to address the complexities of work rules for the SSDI program by implementing a benefit offset paired with direct or indirect supports to facilitate the use of the offset. Eight states (Alabama, Connecticut, Vermont, and parts of California, Maryland, Michigan, Nebraska, and Texas) participated in the program. Beneficiaries who volunteered were randomized into two treatment groups and one control group. For beneficiaries in treatment groups, the Trial Work Period and the Grace Period were replaced by a set of new rules that included a benefit adjustment (reduction) of $1 for every $2 earned above the Trial Work Period threshold ($940 in 2021), called the POD "earning threshold" (treatment 1) or the "total monthly itemized IRWEs above the POD earning threshold" (treatment 2). In one treatment group, benefits were terminated after 12 months of $0 benefit; in the other treatment group benefits were not terminated during the demonstration. All participants in the two treatment groups received counseling on enrollment (Mamun et al. 2021). This aspect of POD was designed to address shortcomings of BOND by allowing eligibility for the benefit offset and assigning benefits counselors immediately upon enrollment (Wittenburg et al. 2021).

Findings from the interim evaluation report by Mamun et al. (2021) suggest that almost all treatment group members (more than 99 percent) received initial contact from their benefits counselors and less than half (38 percent) engaged in individualized work incentives counseling. In general, beneficiaries in the treatment groups were more work oriented (working or looking for work) than those in the control group. Although, beneficiaries reported that POD counselors were approachable and easy to work with, nearly half of treatment group beneficiaries indicated that the POD counseling services were not helpful for increasing their hours worked or earnings. Some beneficiaries reported that the information shared was not relevant to their situation because they were already working. Findings from the interim impact evaluation suggest the offset had no impact on earnings, SSDI benefit amount, or income. It is possible that the benefit offset did not provide a strong enough incentive for beneficiaries to change their work behavior (Mamun et al. 2021). A caveat in interpreting these findings is that the final evaluation report for POD was not available as of 2021, and the interim findings may change with additional data.

Promoting Readiness of Minors in SSI (PROMISE)

PROMISE was a joint venture of SSA with the US Departments of Education, Health and Human Services, and Labor. The demonstration was designed to address the systemic barriers faced by youth in meeting their long-term employment needs. The goal of PROMISE was to improve the provision and coordination of employment services anticipated to result in long-term economic self-sufficiency for the youth SSI recipient.

Five-year PROMISE demonstration grants were awarded in 2013 to five states and one consortium: Arkansas, California, Maryland, New York, Wisconsin, and a consortium of six western states known collectively as Achieving Success by Promoting Readiness for Education and Employment (ASPIRE). ASPIRE consisted of Arizona, Colorado, Montana, North Dakota, South Dakota, and Utah. The demonstration was extended an additional year in all states and ended in 2018 or 2019, depending on the project. The PROMISE final evaluation is anticipated in 2022. Findings discussed here are based on the interim services and impact report (Honeycutt, Wittenburg, Crane, et al. 2018), which focused on receipt of services after 18 months.

PROMISE had five major components: (1) strong intra-agency collaborations; (2) case management; (3) benefits counseling and financial education; (4) career and work-based experiences; and (5) parent training and information. Taken together, these five components were hypothesized to address individual, family, and institutional barriers to long-term economic self-sufficiency among youth. Youth SSI recipients ages 14-16 receiving SSI benefits and their families, residing in PROMISE service areas at the time of enrollment, were eligible to participate. Youth SSI recipients were randomly assigned to a treatment (PROMISE) or control (usual service) group. Between 2014 and 2019, each PROMISE site enrolled approximately 2,000 youth and their families (except California, where N=3,078).

Case management was the cornerstone of the PROMISE demonstration. Case managers played a central role in coordinating services and provided person-centered counseling, conducted needs assessment, and provided information and referral services. California PROMISE ("CaPROMISE") provided treatment group participants with the most extensive supports of all the sites; in addition to the five core components, California treatment group members received referrals for leadership and advocacy training, health and behavior management, access to assistive technology, and training in independent living. The following findings for PROMISE are drawn from Honeycutt et al. (2018), Levere et al. (2020), and Mamun et al. (2019).

Overall, the early outcomes for PROMISE participants were similar in all six PROMISE sites: members of the PROMISE treatment group demonstrated statistically significant positive outcomes after 18 months, compared with control group members. Each of the six programs increased the hours of transition services received, paid employment and support services, and family supports received (Levere et al. 2020).

In general, PROMISE programs offered case management services using one of three models: (1) in Arkansas and ASPIRE, case managers were employed by the lead agencies, and referrals were made to education, employment, and health-related services; (2) Maryland, New York, and Wisconsin hired their own case managers and supplemented additional community resources to support youth and their families; and (3) California offered services directly to participants and required their case managers to be certified in benefits counseling. It should be noted that at all sites any benefits

counseling provided to participants was provided by trained benefits counselors, but not all benefits counselors were case managers.

Case managers in all PROMISE sites met with youth and their families to provide benefits counseling coupled with financial literacy training. Financial training included budgeting, bank accounts, self-sufficiency, and consumer credit. The structure of financial training programs varied among sites. Some sites (Maryland, ASPIRE) started with contracted group training sessions and transitioned to individualized training after enrollment numbers were low for the group sessions. In addition to financial training, California, Wisconsin, and ASPIRE sites provided financial coaching and opportunities to increase savings through Individual Development Accounts, state-matched college savings plans, and Achieving a Better Life Experience (ABLE) accounts (Honeycutt et al. 2018).

Findings from the interim process and implementation analysis highlighted features of each PROMISE site that contributed to the outcomes (Mamun et al. 2019). In Arkansas, more than 92 percent of youth were engaged in PROMISE three years after the program began. Arkansas was able to accomplish this by converting some of its recruitment staff to retention staff and increasing outreach efforts. About 59 percent of youth received case management services; and almost all participating youth had identified career goals and plans to achieve the same. Two-thirds of participating youth had started summer work experiences, and about 25 percent completed the work experience for two summers. Parents in the Arkansas PROMISE were also highly engaged in the program. At the end of three years, about 87 percent of parents of participating youth had their own PROMISE goals and were referred to education and employment services (Mamun et al. 2019). At the end of 18 months, Arkansas PROMISE was also able to increase employment rate, hours worked, and earnings of treatment group youth in comparison with control group youth.[7] The program did not have any impact on youth education or self-determination outcomes or parent employment or earnings (Mamun et al. 2019).

ASPIRE prominently featured case management services. ASPIRE case managers were supposed to meet with all youth participants and their families for at least 30 minutes once a month to provide benefits counseling, financial education, information and advocacy support, and self-determination support. The interim process and impact analysis indicated that 86 percent of youth remained engaged in ASPIRE. However, the program fell short of its case management and benefits counseling goals; only 47 percent of all youth participants received case management services, and most case management contacts were less than 20 minutes; and 46 percent of families received benefits counseling services. ASPIRE sites met their goal for career engagement, where 31 percent of youth had engaged in competitive employment by the second year. The program also had a positive impact on the receipt

[7] For treatment group members, PROMISE increased employment by 31 percentage points, average hours worked by 2.7 percentage points, and average earnings by 162 percentage points compared to the control group (Mamun et al. 2019).

of transition services by youth and families, but no impact on youth education or self-determination outcomes, parent education, or earnings (Mamun et al. 2019).

CaPROMISE focused on providing intensive family-centered case management and work experiences for youth. CaPROMISE had a positive impact on youth employment and earnings and on parent earnings, education, and training in comparison with the control group.[8] The positive impacts on parent outcomes could be linked to the program's strong emphasis on family-centered services.

Maryland, New York, and Wisconsin experienced early challenges in implementation. In Maryland, the PROMISE program did not meet its benchmark of providing 8 to 10 case management contacts per month for youth and their families, possibly due to staff dedicating most of their time to recruitment rather than retention. In New York, case managers were responsible for providing intake evaluation and providing case management services or had additional non-PROMISE job duties that limited their availability to provide PROMISE services. In Wisconsin, there was a low uptake of services by youth and their families. Although 95 percent of families engaged in case management, only 65 percent were referred to job development, 39 percent had paid work experiences, 36 percent had any contact with a benefits counselor, and 14 percent completed soft skills training. A combination of factors such as poor referral rates, non-PROMISE-related demands on counselor time, and conflicting family priorities may have contributed to the low uptake (Mamun et al. 2019). Maryland PROMISE program did not meet its benchmark of providing 8 to 10 case management contacts per month for youth and their families, possibly due to staff dedicating most of their time to recruitment rather than retention. At the 18-month analysis, Maryland and New York were successful in increasing services delivered and youth earnings but did not have a detectable impact on other outcomes. Wisconsin also demonstrated increases on program participation, youth earnings, and youth health insurance coverage (Mamun et al. 2019).[9]

Further analysis of PROMISE services (Levere et al. 2020) suggest that youth and family services were associated with favorable outcomes. However, because youth and family services were provided concurrently, it is not possible to disentangle the impact of each separately and no causal inference can be made about the impact of each. Benefits counseling along with networking, support, parent training, and information on their youth's disability were bundled as "youth-oriented family

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[8] CaPROMISE increased by 5 percentage points the share of parents reporting that they or their spouse had attended or completed job skills training or education during the 18 months following random assignment. CaPROMISE increased the self-reported earnings of parents in treatment group by $122 compared to the control group. However, a similar increase was not observed in SSA records, possibly due to differences in reference periods for data collection (Mamun et al. 2019).

[9] At the 18-month evaluation, Wisconsin PROMISE showed a 1 percentage point impact on health insurance coverage for youth in the treatment group compared with the control group—small but statistically significant (Mamun et al. 2019).

services." The "family-oriented family services" bundle included case management, education or training supports, employment-promoting services, and financial education services provided to family members other than the youth receiving SSI (Levere et al. 2020).

The use of youth-oriented family services had a moderate, non-significant association with youth outcomes after controlling for youth and family characteristics. Typically, youth who used services had better outcomes than youth who did not (except for SSI payments). However, there was no statistically significant relationship between use of family services and youth outcomes. Although the findings suggest association and do not demonstrate a causal relationship between either bundle of services and youth outcomes, they provide preliminary evidence of the potential importance of those services in the youth's transition process.

Nye-Lengerman et al. (2019) examined emerging lessons from the PROMISE demonstration. Their findings suggest that successful PROMISE programs demonstrated flexible service delivery models, strong leadership, solid interagency collaboration, opportunities for professional development for staff, and family engagement.

Youth Transition Demonstration (YTD)

The YTD was a set of projects aimed at youth who were receiving or at risk of receiving SSI benefits. For the evaluation, SSA selected six sites from a larger group of sites that had participated previously through cooperative agreements or as pilot programs. Three projects entered the evaluation in 2006-2007, and three in 2008. In total, these six projects randomly assigned more than 5,000 youth who volunteered to participate (Fraker, Mamun, et al. 2014).

Each site was able to define its specific target population and approach, with most serving SSI recipients and all evaluation sites offering a set of core services developed for YTD based on the *Guideposts to Success* model (NCWD/Y 2005, 2009). These included work-based experiences, system linkages, youth empowerment, family supports, social and health services, and benefits counseling. The intervention also involved waivers to SSA benefit rules that relaxed the conditions around the Student Earned Income Exclusion, the Plan to Achieve Self-Support, and Individual Development Accounts; increased the Student Earned Income Exclusion; and provided continued benefit payments and Medicaid coverage under Section 301 for the period of participation in YTD for those found no longer disabled or who turned 18 and did not meet the adult definition of disability (Rangarajan et al. 2009).

The model of benefits counseling and case management used in YTD was characterized by two features. First, they were integrated with a larger set of services and supports provided as a way to facilitate access and use of other services and supports, both within and beyond the program. For example, benefits counseling was tailored to explain both the waivers for which participants were eligible and the regular SSA rules that would apply after the program had ended (Rangarajan et al. 2009). The

second feature was substantial local flexibility, which reflected differing participant needs, service environments, and the capacities of and choices made by the organizations implementing YTD programs. For example, the Maryland site served youth who were not currently receiving SSI benefits, so benefits counseling emphasized other benefits, such as the Supplementary Nutrition Assistance Program (SNAP) and Temporary Assistance to for Needy Families (TANF) (Fraker, Baird, et al. 2012). The West Virginia site operated in a fragmented service environment, where most service providers had limited capacity for outreach and so depended on youth seeking out their services. For this reason, an important part of case management for the West Virginia program was helping youth and their families to identify supports (Fraker, Mamun, et al. 2012). The YTD program based in Bronx County (NY) structured many of its activities around "Saturday Sessions" in which youth and their families participated in group activities. Elements of benefits counseling and case management that could reasonably be provided in a group setting, such as general information on SSA benefit rules, were incorporated into these sessions, with additional case management and benefits counseling provided individually as needed (Fraker, Black, Broadus, et al. 2011).

The variation across demonstration sites allowed for the exploration of many different models, but also makes it difficult to aggregate findings across sites. Indeed, the final report considers each of the sites separately (Fraker, Mamun, et al. 2014). Also, as is the case in most demonstrations reviewed here, it is impossible to isolate the effects of case management and/or benefits counseling, as both were integrated into a larger program. Four of the six programs increased at least one measure of earnings and/or employment, and all but one increased at least one measure of youth income, often by increasing SSI benefits as extended eligibility through Section 301 (Fraker, Mamun, et al. 2014). However, it is unclear to what extent these results were caused by case management or benefits counseling.

State Partnership Initiative (SPI)

SPI was designed to respond to persistent employment issues, low rates of employment, low earnings, and inadequate use of work incentives programs by individuals with disabilities. SSA partnered with the US Department of Education's Rehabilitation Services Administration (RSA) to provide funding for this demonstration. Eighteen states participated in SPI between May 2001 and September 2004, of which 12 were funded by SSA and 6 by RSA. The focus of the initiatives varied slightly depending on the source of funding: SSA-funded states provided information, better access to vocational supports, and modified program rules (waivers) to allow for more earning and saving. RSA-funded states focused heavily on changing service delivery models. Participating states designed their own interventions, choosing from a menu of seven barriers to address that are most frequently faced by SSDI beneficiaries and SSI recipients (Peikes et al. 2005). All states provided benefits counseling; all states except North Carolina, Ohio, and

Oklahoma provided Medicaid waivers and buy-ins. Most states provided one or more employment services in the form of placement assistance or case management (Kregel 2006a).

Though each state differed in how it implemented benefits counseling, the common elements among the states were information and referral, problem solving, benefits assistance, benefits planning, and long-term benefits management. Three states (New Hampshire, New York, and Oklahoma) used random assignment to configure their treatment and control groups (Peikes et al. 2005). Each of these three states offered multiple intervention packages. New York offered two packages: The first package provided benefits counseling and tested changes to SSI regulations that allowed SSI recipients who worked to retain and save more money.[10] The second package added employment services to help participants find, apply for, and maintain employment. Oklahoma offered voucher services to participants who had a mental illness, received SSI, and were not employed at intake. The vouchers allowed SSI recipients to obtain vocational services from vendors of their choosing. All its participants received benefits counseling (averaging 10 hours per month) and job services through the vouchers (averaging 5 hours per month). More than three-quarters of participants received case management (averaging 7 hours per month) (Peikes et al. 2005). Supported employment, placement assistance, situational assessment, job training, psychosocial rehabilitation, job accommodations, or transportation assistance were offered less frequently. New Hampshire provided SSI recipients and SSDI beneficiaries with a choice of and control over their vocational services through the assistance of a service resource.

SPI benefits counseling interventions tended to produce modest impacts on employment and earnings. In New York, where benefits counseling was offered in conjunction with employment services, the package was found to be more effective than New Hampshire's intervention providing counseling only. New Hampshire saw a 30 percent decline in employment rates for the treatment group compared to the control group. Qualitative case report data from New Hampshire's SPI project indicate that a few participants chose to leave jobs to pursue education, training, and certification that would further their career goals (Cloutier et al. 2006). It is possible that the decrease in earnings could be attributed to this shift into education, but it is unknown how much of the drop in earnings can be attributed to this cause.

In Oklahoma, the intervention focused on individuals with psychiatric disabilities, who received benefits counseling, case management, and a voucher for employment services. Employment rates for treatment group members in New York and Oklahoma increased 9 to 18 percentage points. Earnings, on the other hand, did not change (Peikes et al. 2005).

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[10] SPI demonstration tested waivers to SSI regulations that allowed recipients to retain more of their earnings and benefits counseling. In other. For a detailed description of the waivers, see Peikes et al. (2005, Appendix A).

There are several possible explanations for these findings. First, it is possible that benefits counseling in the absence of other employment support services is of little value. Benefits counseling coupled with vouchers for employment services, case management, and more important, assistance to find and keep a job could be effective. The combination of benefits counseling with employment services is particularly important, because the pattern of results suggests that simply providing information via benefits counseling without assistance with job search and placement will not affect employment status or earnings.

Second, about 79 percent of individuals who participated in this demonstration experienced mental or emotional disabilities, and 14 percent had physical disabilities (Kregel 2006b). It is possible that the intervention has a differential effect on different subpopulations.

Last, the follow-up period for the evaluation was likely too short to detect impacts that might take more time to emerge. Three months was probably not enough to capture any true changes in earnings that could have occurred due to benefits counseling. It is unlikely for any new employee to experience substantial increases in wages within their first three months. Longer-term follow-ups, as long as four years, might be necessary to capture true changes in earnings.

Accelerated Benefits (AB)

The AB demonstration was authorized by Congress in 1999 to examine alternatives to SSDI's 24-month waiting period for Medicare. The rationale behind AB was that SSDI beneficiaries could experience serious health care needs because of poor health and limited functioning. Acknowledging the relationship between health and employment, AB was designed as a five-year program to test the impact of providing health care services on overall health, employment outcomes, and reliance on SSDI benefits (Michalopoulos et al. 2011). Two versions of AB were tested; both versions provided health care benefits to SSDI beneficiaries until they were eligible for Medicare. The second version of AB, called AB Plus, offered additional services in the form of telephone counseling to help beneficiaries navigate the health care system and return to work if they desired to do so.

AB Plus participants were provided access to telephone counseling services through a health care management company (Weathers et al. 2010). Specifically, AB Plus participants received a baseline assessment and were assigned a nurse, coach, or both. Nurses assisted with navigating the participants' health care needs. Coaches, who were psychologists or social workers, guided participants through a Progressive Goal Attainment Program to reduce psychosocial barriers to rehabilitation progress, promote reintegration into life-role activities, increase quality of life, and facilitate return to work.[11] Its overarching goal was to encourage active steps toward seeking

[11] For information about the Progressive Goal Attainment Program (PGAP): http://www.pdp-pgap.com/pgap/en/index.html.

employment by optimizing work-life roles, by using behavioral coaching strategies to minimize barriers to rehabilitation. The final component of the AB Plus program was employment benefits counseling, which was available to participants who showed interest in returning to work.

Between October 2007 and January 2009, the demonstration enrolled 1,939 participants in a treatment group (AB or AB Plus) or the control group. Process and outcome evaluations of the AB demonstration were conducted. Both health-related outcomes (e.g., health care use, health status, unmet needs) and employment-related outcomes (e.g., job preparation, job search, use of work supports) were tracked (Michalopoulos et al. 2011).

Although the AB intervention did not cause changes in participants' labor market outcomes, the AB Plus intervention had a significant short-term impact on employment. Participants in AB Plus saw modest increases in short-term employment compared with the control group: a 4.6 percentage point difference in receipt of rehabilitation or employment services, 3.3 percentage point difference in receipt of services from the Ticket to Work program, and most notably, a 5.3 percentage point difference in employment during the second calendar year following enrollment. Subsequently, participants also demonstrated an increase in annual earnings of $831 by the second year (Weathers and Bailey 2014). In general, AB plus participants who used employment and benefits counseling had experienced higher levels of labor market activity. Weathers and Bailey 2014 note that "12.3 percent of employment and benefits counseling users participated in the Ticket to Work program, compared to 3.1 percent of those who did not use those services" (Weathers and Bailey 2014, 604).

However, these gains were short lived, not sustaining into the third year after enrollment in the study. It is possible that fear of losing their SSDI benefits triggered beneficiaries to adjust their labor market participation to preserve benefit receipt.

Subgroup analyses revealed that the earnings gain was highest in beneficiaries ages 45–49 or younger than age 40. Beneficiaries with a bachelor's degree and those experiencing respiratory and sensory limitations experienced higher gains in earnings than those without.

Findings from the AB demonstration suggest that providing a health insurance package (AB) is not sufficient to increase labor market activity. However, adding employment and benefits counseling (AB Plus) was marginally effective in improving short-term earnings in a small but substantial group of new beneficiaries.

Mental Health Treatment Study (MHTS)

The MHTS aimed to increase the employment outcomes (including earnings), health status, and quality of life of individuals with schizophrenia who were SSDI beneficiaries (Frey et al. 2011). It was designed on the heels of a large body of evidence on medical management integrated with supported employment services to improve employment outcomes of people with schizophrenia.

The study was fielded between November 2006 and July 2010 and targeted beneficiaries with schizophrenia or an affective disorder in 23 sites throughout the United States. Sites were eligible to participate if they had the capacity to deliver behavioral health interventions and had documented fidelity in delivering supported employment. Participants were eligible if they were ages 18–55, experiencing schizophrenia or affective disorders, and not experiencing any terminal illness. More than 2,200 beneficiaries were randomized into treatment and control groups and participated in the intervention for 24 months. The treatment group received supported employment services and evidence-based mental health services and supports including benefits counseling (where possible). The study design included strict and periodic quality management reviews conducted by nurse care coordinators. The primary outcome measures of interest were employment rate, earnings at main job, hours worked, number of months employed, health status, and quality of life. The analytical plan included both exploratory and confirmatory hypotheses, reflecting a well-planned analysis design that is present in some but not all demonstrations.

There was a 20 percentage point difference in the employment rates between beneficiaries in the treatment group and the control group. Beneficiaries in the treatment group were more likely to be employed in any job as well as in competitive jobs. There were also statistically significant differences in employment rate among subgroups based on age, gender, diagnosis, and educational status. Beneficiaries in the treatment group were also more likely to be steady workers rather than erratic or minimal workers. Factors that predicted employment rate included being enrolled in the treatment group, baseline physical health, previous work experience, and months receiving SSDI. A large, statistically significant difference was observed between the treatment group and the control group on earnings.

A closer examination of the benefits counseling and case management services delivered through Individual Placement and Support (IPS) revealed that 69 percent of participants in the treatment group received benefits counseling and 54 percent received mental health case management services at any time during the two-year study period. It should be noted that of the 54 percent who received the case management services, about a third used off-site locations. This lack of comprehensive onsite case management services, a central component of the IPS model, could have negatively influenced the program outcomes. Case management services also were not tracked uniformly across all sites because sites did not include case manager interactions in their monthly data collection form. Some sites provided case management services by telephone; however, these services were not compensated, leading to their possible deterioration or discontinuation.

Overall, evidence through the rigorous evaluation of MHTS and other empirical research (discussed later in this chapter) suggests that supported employment increases employment for beneficiaries (Frey et al. 2011). Because of the integrated nature of services provided through IPS's supported employment, it is challenging to isolate the impact of benefits counseling or case management only. Nevertheless, case

management, benefits counseling, and job placement services are critical components of supported employment programs,[12] which have demonstrated meaningful improvements in employment status.

Supported Employment Demonstration (SED)

The SED is a multi-component intervention targeting applicants for SSDI and SSI with mental impairments who were denied disability benefits on initial determination (Marrow et al. 2020; Taylor et al. 2020). SED is based on evidence-based supported employment and integrated behavioral health components. SED participants also receive additional funds to cover copays for medical treatment, work-related expenses, and other financial barriers (Marrow et al. 2020). The intervention aims to improve clinical recovery, increase employment, and subsequently keep individuals from needing SSDI or SSI.

SED was designed on the heels of MHTS, but the primary objective of SED is to test the effectiveness of supported employment services at an earlier stage. Participants in SED were randomly assigned to one of three treatment arms: Full-Service, Basic, and Control (approximate N=1,000 each arm). The multi-component intervention for its Full-Service and Basic treatment arms was delivered by a team of experts including a team lead, at least one IPS specialist, and a care manager. In addition, the Full-Service treatment included a nurse care coordinator. Benefits planning was embedded within the services provided through the IPS model of supported employment for the Full-Service and Basic treatment arms.

Findings from the interim process evaluation report from the first two years of the demonstration show that more than half of the sites (57 percent) were able to achieve high fidelity of implementation (Marrow et al. 2020). Participants experienced many unmet needs related to food, shelter, and medical care. SED staff had to leverage resources in the community to provide wraparound services to meet participants' medical and care needs. Overall, initial engagement with the SED team was positive (more than 92 percent) and 40 to 50 percent of participants continued to meet with their SED specialist monthly (Marrow et al. 2020). Final data on employment and clinical recovery outcomes are due in 2022.

[12] Traditional supported employment programs may include services such as career exploration, job search, customizing job duties or work schedules. In contrast, the IPS model promotes recovery through work and is defined by the following principles: (1) a focus on competitive employment, (2) rapid job search, (3) eligibility based on client choice, (4) attention to client's preferences in employment services and supports, (5) integration of employment and clinical services, (6) time-unlimited support, and (7) systematic job and employer relationship development. Some supported employment programs may incorporate other services such as cognitive behavioral therapy, occupational therapy, etc.

Project NetWork

Project NetWork was fielded between 1991 and 1995 to test the impact of case management as a means of promoting employment among persons with disabilities (Kornfeld and Rupp 2000). The demonstration targeted both SSI recipients and SSDI beneficiaries. Participants were recruited via two streams: (1) SSI applicants who volunteered and (2) SSI recipients and SSDI beneficiaries who were recruited through an outreach effort. Study participants were assigned to either a treatment or a control group. Those in the treatment group received case management, benefits counseling, and individualized employment services. Under the Project NetWork waiver, program rules that were considered a disincentive to working were waived. For SSDI beneficiaries, the Trial Work Period was suspended for the first 12 months. In other words, months with earnings did not count against the Trial Work Period and did not result in benefit suspension. For SSI recipients, Project NetWork waivers prevented a continuing disability review from being triggered (Kornfeld and Rupp 2000; Rupp, Bell, McManus 1993).

Project NetWork was implemented in eight sites and tested four case management models. In the first three models, there were differences in the organizational role of the case manager. In the first intervention, case management was provided by SSA staff; in the second, case management was provided by contracted rehabilitation organizations; in the third, case managers from Vocational Rehabilitation agencies were "outstationed" in SSA offices. The fourth model was designed to be less intense and focus on information and referral services, rather than direct services to clients (Kornfeld and Rupp 2000).

Findings from the demonstration revealed that participants in the intervention groups received more return-to-work services than the control group did, including benefits counseling, physical therapy, work assessments, and job search services. There was a statistically significant increase in earnings for the treatment group compared to the control group for the first two years following random assignment. However, those differences did not sustain during the third year following random assignment.

SSI and SSDI benefit receipt did not change between treatment and control groups during the follow-up period. Similarly, self-rated health also did not change. Further analysis of earnings and receipt of benefits by impairment subgroup did not reveal any major trends except for beneficiaries who experienced musculoskeletal disorders. Beneficiaries with musculoskeletal disorders saw a 2.1 percent reduction in receipt of SSDI benefits. Despite modest gains observed, the cost of administering Project NetWork exceeded the benefits realized from the program.

Project NetWork findings suggest that case management might not be relevant for all SSDI beneficiaries and SSI recipients, given that there was no sustained difference in earnings between the treatment group receiving case management and the control group receiving information and referral. Case management services might be of value

when beneficiaries or recipients are less job ready or experience limitations that they require coordination of vocational, rehabilitation, and employment services.

EVIDENCE FROM ADDITIONAL EMPIRICAL RESEARCH

Empirical research outside of SSA demonstrations is scant on the intersection of benefits counseling or case management and welfare programs. A few studies have examined the effectiveness of the case management approach using administrative data. The following section describes research conducted with the goal of demonstrating the effect of SSA programs, with subpopulations or using methodology that addresses some of the shortcomings of SSA demonstration designs.

Braitman et al. (1995) examined the barriers experienced by employed and unemployed clients in a case management program. Although the authors initially hypothesized fear of losing benefits, lack of family support, and transportation as primary barriers, their findings suggest that personal factors such as motivation, ability to tolerate criticism, and ability to self-initiate were ranked as important factors that determine employment. Many participants, regardless of employment status, rated illness-related symptoms as a barrier. Case managers need to be aware of the debilitating effects of illness, its side effects, and how that might affect work performance.

Bloom, Hill, and Riccio (2003) used consolidated data from multiple welfare programs to demonstrate the value of case management. Personalized attention in the form of spending time to understand the complex life circumstances of clients and their families and tailoring services to their specific needs was considered a critical component of a successful case management program. Peck and Scott (2005) examined the use of a Case Management Screening Guide to improve ability of case managers to identify the unique needs of their clientele. Use of the screening tool was associated with increased understanding of the strengths and weaknesses of clients, the number of employment services used by clients, case closures, and work-related activity. However, use of the screening tool had no impact on five-year employment status.

Evidence supporting the use of a case management model to improve employment status is strong within certain subpopulations such as individuals with mental health issues. A strengths-based case management model that was implemented with high fidelity had increased competitive employment of participants after 18 months of intervention (Fukui et al. 2012). A high-fidelity model of case management is characterized by structural components (low caseload sizes, periodic group supervision including case presentations, etc.) and practice components (use of the strengths assessment and recovery plan tools, use of natural supports in the workplace, and in-person service delivery) (Fukui et al. 2012).

Evidence-based practices such as assertive community treatment (ACT) and supported employment incorporate case management as a critical component. Both interventions are frequently used with adults with mental health issues. ACT integrates

principles of traditional rehabilitation and case management into one program. The key hallmark of ACT is the provision of case management and rehabilitation through one integrated team, where the case managers broker services and provide information and referral, and the rehabilitation team addresses function and employment-related goals. ACT case managers are also characterized by smaller caseloads of approximately 30 clients each and a well-defined job description (Boyer and Bond 1999; Ellison et al. 1995). Future adaptations of case management programs for use by SSDI beneficiaries or SSI recipients with mental health issues could leverage ACT best practices such as deploying integrated teams that address medical, social, and employment related issues.

Olney and Lyle (2011) conducted in-depth interviews with 12 SSDI beneficiaries and SSI recipients to understand the employment barriers they experienced. Findings suggest that participants were leery of losing the safety net of benefits. Some participants intentionally kept their earnings low, did not pursue career advancement opportunities, and sought out low-paying jobs. Participants engaged in cost-benefit analysis before deciding when, where, and how much to work. Those who were supported by family members' health insurance plans were more likely to reduce their reliance on SSA benefits.

The timing of benefits counseling is an important determinant of employment outcomes. In addition to traditional services, VR agencies that provided timely[13] benefits counseling observed greater SGA-level employment compared to agencies that waited to provide services (Honeycutt and Stapleton 2013). A similar effect was observed in the Kentucky Substantial Gainful Activity demonstration sponsored by the US Department of Education (Martin and Sevak 2020), adding further evidence that providing benefits counseling early was a critical component of successful programs. Martin and Sevak (2020) noted that eligibility determination for participants in the Kentucky SGA demonstration was completed within 2–10 days of initial contact, team meetings were conducted within 30 days from initial contact, and Individualized Plan of Employment goals were established within 30–60 days from initial contact.

Evidence supporting the value of a written benefits analysis plan is mixed. A written benefits analysis plan was not associated with increased earnings and had a modest impact on employment status for those employed for at least one quarter (Wilhelm and McCormick 2013). For transition-age youth who received benefits counseling and employment services (through PROMISE), the provision of benefits

[13] Timeliness of services was measured as Usual Wait Time. More than half of the study sample in Honeycutt and Stapleton (2013) had wait times of three months or less and about 90 percent had wait times of nine months or less. Of course, there are individual, agency-level, and state-level variations in timeliness of services. In general, each additional month of waiting for services is associated with a 1.2 percentage point reduction in SGA months (months of earnings at or above the SGA level after VR application, as recorded in SSA's Disability Control File).

counseling preceded by a "warm handoff"[14] steeped in trust and client-centered practices may be helpful (Schlegelmilch et al. 2019). Rather than being provided detailed written summaries of benefits analysis, youth and their families appreciated being met "where they are" with limited, relevant, and bite-sized information that was not overwhelming.

In general, demonstration projects did not control for or consider the effect of non-random selection of participants. When participants are included in a study on a volunteer basis, they can differ from the broader sample pool of SSI recipients and SSDI beneficiaries in many ways. Volunteer participants could be more motivated to work on their employment goals or have easy access to employment services within their community. It is likely that these differences in sample characteristics contributed to or caused changes in employment status and earnings, rather than the actual intervention provided. To address the issue of non-representative sample selection, Nazarov (2013)[15] and Iwanaga et al. (2021)[16] used data on SSI recipients and SSDI beneficiaries and employed quasi-experimental methods and propensity score matching to examine the effects of employment and benefits counseling services on earnings, hours worked, and labor market activity among adults and youth, respectively.

Findings suggest non-significant differences in case closure (due to employment) between those enrolled in benefits counseling and the control group. Findings from both studies suggest statistically significant increases in the estimate for earnings and hours worked among adults and young adults after controlling for non-random selection. Nazarov (2013) observed a 17 percent increase in earnings and a 20 percent increase in hours worked for adult beneficiaries and recipients in the treatment group. Iwanaga et al. (2021) noted that the youth in the treatment group worked fewer hours but had higher earnings than the control group. Taken together, these studies demonstrate the importance of controlling for non-random selection to uncover the *impact* of the intervention.

Tremblay et al. (2004, 2006) used a quasi-experimental design with two groups of matched comparison groups to examine the impact of specialized benefits counseling among participants enrolled in Vermont SPI. Five variables were used to

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[14] When families seemed reluctant to transition from a VR counselor to a benefits counselor, the process of instilling trust and facilitating a rapport was described as a "warm handoff" (Schlegelmilch et al. 2019).

[15] Nazarov (2013) used data from the Case Management Administration System from the New York State Adult Career and Continuing Education Services (ACCES-VR). Study participants (N=38,125) were SSI/SSDI beneficiaries who received VR services between October 2003 and October 2009 and who had fully developed Individualized Plans of Employment.

[16] Iwanaga et al. (2013) used data (N=19,383) from the Case Service Report (RSA-911) for the 2018. The inclusion criteria for this study were (1) ages 18–35 (i.e., transition-age youth and young adults), (2) a primary diagnosis of intellectual disabilities at intake, (3) SSI recipients at intake, and (4) received VR services.

draw two comparison groups:[17] (1) experience as a VR consumer, (2) experience as an SSDI beneficiary or SSI recipient, (3) primary VR disability, (4) start date for VR services, and (5) time elapsed between eligibility and initiation of VR services. These variables were previously demonstrated as having an impact on employment outcomes. Comparing earnings over four years, the group that received specialized benefits counseling fared consistently better than the comparison groups. The adjusted difference in earnings between the intervention group and comparison groups was more than $1,200 per person per year. Analysis of within-group differences for the counseling intervention group indicated an almost $500 increase in earnings by the seventh and eighth quarters from baseline.

These findings add to the growing body of evidence supporting the effectiveness of benefits counseling programs, even after controlling for race, gender, disability type, and Social Security beneficiary type (Tremblay et al. 2004; Tremblay et al. 2006).

KNOWLEDGE GAPS AND LESSONS FOR POLICY FROM DEMONSTRATION PROGRAM FINDINGS

Findings from SSA demonstrations contribute to the growing body of evidence on the effectiveness of employment and benefits counseling. There is moderate to weak evidence that case management and benefits counseling contribute to increases in employment or earnings or to decreases in reliance on SSI or SSDI benefits. These findings should be interpreted in the context of programmatic, structural, and contextual differences among the demonstrations. The following section summarizes lessons learned from current demonstrations.

In almost all demonstrations, benefits counseling and case management were offered in conjunction with job placement and VR services. Examples of VR services included unpaid career and work exploration, job training, service learning, job shadowing, work sampling, and job interview training (Honeycutt et al. 2018) and soft skills training such as communication skills, time management skills, and networking skills (DOL 2018). There is strong evidence to suggest that the combination of benefits counseling and VR services results in better employment outcomes (employment status, earnings, hours worked) when compared to benefits counseling or case management in isolation. Future demonstrations should continue offering these two services in tandem.

The timing and nature of benefits counseling is of utmost importance. Preliminary evidence suggests that beneficiaries who waited too long (from the time of application to VR services) to receive benefits counseling and employment services tended to earn less and work fewer hours overall (Honeycutt and Stapleton 2013; Martin and Sevak 2020). Chapter 5 in this volume provides detailed evidence on the importance of early

[17] See Tremblay et al. (2004) for additional details on how the samples for the comparison groups were defined and constructed.

intervention programs that target individuals who are at risk and not yet detached from employment. Of the types of benefits counseling, a tailored, coaching-based intervention was generally found to be more effective than an information-sharing intervention. For example, in a coaching-based approach, beneficiaries are guided through various strategies to track their income, such as the use of calendar tools to track Extended Period of Eligibility (Chambless et al. 2011). Where benefits counselors provided tailored counseling and helped participants develop employment-related goals and actionable steps (e.g., PROMISE and AB Plus), increases in earnings and employment were more likely.

In comparison to other demonstrations, BOND arguably had the most extensive benefits counseling in its provision of WIC and EWIC services. An important finding of BOND was that WIC and EWIC counselors reported feeling burdened by providing post-entitlement services to beneficiaries. Another issue with the implementation of BOND was inadequate training and lack of awareness among counselors of how BOND offset worked. This resulted in a certain level of confusion among beneficiaries about qualifying for and participating in BOND. Improved training and continuing education opportunities could help counselors be better prepared to deliver new programs.

There was wide variation in how benefits counseling was defined and how programs were structured within SSA demonstrations. The duration and intensity of benefits counseling varied considerably or could not be clearly documented between sites. In general, there was a lack of adequate information regarding what happens in a counseling or case management interaction. Even in programs that allowed prolonged engagement and had documentation of the hours spent in counseling and case management, there was scant publicly available information (except BOND) on the content of the sessions.

Last, the availability of integrated social and health care services provides a more optimal environment for implementing benefits counseling programs. There are several examples of integrated care models that support social and health care needs of adults with disabilities and older adults. For example, empirical research on supported employment services integrated with psychiatric care has shown them to increase employment. The integrated ACT model of case management, where services are provided in teams of medical and social service professionals, is highly successful (Bond et al. 2001; Burns et al. 2001; Dixon 2000). For individuals with a dual diagnosis of mental health and substance use issues, peer-led, community-based, integrated programs are considered a best practice (Coldwell and Bender 2007; Bond et al. 2001; Dixon 2000).

FUTURE RESEARCH & LEARNING AGENDA FOR SSA

SSA administers safety net programs that provide income security to families and individuals based on age, disability status, or work credits. These programs operate in a constantly changing environment of economic trends, labor markets, demographic

shifts, and government priorities (Autor, Maestas, and Woodberry 2020). SSA's demonstrations offer rich data and contextual information to understand how, when, and what works in benefits counseling and case management for beneficiaries. This section uses evidence from past and current SSA demonstrations and other empirical research to inform SSA's future policy agenda.

Defining and Operationalizing Benefits Counseling and Case Management through Fidelity Metrics

Establishing benchmark parameters for the content and structure of benefits counseling and case management could be a critical step that enables more accurate monitoring of SSA demonstrations. One way of achieving this is through development and implementation of treatment fidelity metrics for benefits counseling and case management. Treatment fidelity was a critical component of MHTS and the newer SED. Fidelity of intervention is a critical component of determining intervention effectiveness; it is a systematic approach to evaluate and document adherence to the intervention as it was intended. In other words, fidelity is the extent to which an intervention, when implemented, is true to the underlying therapeutic principles (Teague, Bond, and Drake 1998; Waltz et al. 1993). Treatment fidelity was a critical component of MHTS and the newer SED.

Fidelity assessments allow researchers and practitioners to engage in reflective appraisals of the intervention. Fidelity assessments can also inform replicability of findings (or lack thereof) across repeated research and implementation efforts and to isolate intervention program components, as in differentiating between case management and information and referral. For example, counseling theory suggests that active ingredients for any counseling program should include rapport and trust building and deep engagement between the counselor and the beneficiary or recipient. In the absence of opportunities to engage deeply and problem solve collaboratively, counseling sessions are reduced to information and referral sessions. The impact of building trust and rapport was further demonstrated by the success of coordinated, warm handoffs over written benefits summaries within PROMISE (Schlegelmilch et al. 2019).

Developing metrics for and documenting quality indicators for benefits counseling and case management beyond the number of sessions or frequency of contact can provide additional insights into the effectiveness of those services. Such benchmarks for fidelity should specify minimum criteria for content and structure. Typically, fidelity measures include two sets of criteria: (1) structure and process of intervention delivery (the *how*) and (2) content integrity and differentiation of intervention components (the *what*) (Feely et al. 2018). The criteria related to structure and process address the context in which the intervention happens. For example, the number of counseling sessions ("dosage") and whether counseling is provided online or face-to-face ("mode") are structural aspects of intervention fidelity, whereas the specific information or knowledge shared are the active ingredients or core content of

the intervention. Incorporating fidelity measurements into a process and impact evaluation will help SSA evaluate the quality of benefits counseling and case management.

Study Design–Related Issues

Although benefits counseling and case management were critical components of several SSA demonstrations, the unique impact of the programs remains unknown. Because the evaluations were not designed with the specific goal of isolating the effectiveness of case management or benefits counseling (except AB and BOND), the overall effectiveness of these two services in isolation remains unclear. Future demonstrations should consider multi-arm studies or factorial designs of small pilot populations that offer benefits counseling or case management (in conjunction with VR services) tested against other approaches such as benefits offset, work incentives, and the like.

Multi-arm and factorial designs with small clusters of matched or randomly selected beneficiaries or recipients could be helpful in differentiating between small variations in benefits counseling or case management and solidifying the isolated or unique effectiveness of either. For example, multi-arm and factorial designs can be used to simultaneously compare a four-week versus six-week benefits counseling intervention or a telephone versus face-to-face intervention against a single control group. A second approach would be to explore testing multiple clusters of subpopulations sequentially to allow implementing and testing incremental changes to case management and benefits counseling. For example, case management or benefits counseling services can be tested among multiple subgroups based on type of impairment (physical versus sensory versus cognitive) or level of motivation and job readiness.

The evaluation designs in SSA demonstrations included both random sampling and volunteer participation. A recruitment strategy has implications for demonstrating the overall effectiveness and generalizability of findings. Random sampling offers protection against biases in the characteristics of participants in a study. Participants who self-select or volunteer for demonstrations might be highly work oriented or more motivated to return to work. Individuals who turned down enrollment in SED, for example, cited general lack of interest, assumed they cannot work, and cited health issues and other life obligations more frequently than did individuals in the treatment group. Most demonstration evaluations used non-representative selection to recruit participants.

Future programs should consider the effect of non-representative sample selection on employment outcomes and adjust for the same using study design features or statistical controls.

A second issue in the design of demonstrations is the lack of clarity in explaining the causal mechanism between benefits counseling and/or case management and employment outcomes such as earnings or hours worked. A causal mechanism is a

postulated set or sequence of events that links a particular event to an outcome. Causal mechanisms are helpful in explaining *why* certain things happen and to uncover the underlying processes that cause the change (Imai et al. 2013). In social and behavioral science research, a weak causal link between the hypothesized intervention and proposed outcomes can undermine the external validity of a study. If the primary purpose of benefits counseling and case management is to provide accurate information and to monitor use of benefits, the proximal or direct outcome of such intervention is likely to be an increase in knowledge or awareness of benefits and work incentives. Increased knowledge and awareness of (loss of) benefits may motivate some individuals to seek or sustain employment or increase their work hours and earnings, but such outcomes should be considered an indirect effect rather than a direct result of benefits counseling.

Future SSA programs should choose appropriate outcomes for evaluation by carefully considering the proximal outcomes of benefits counseling and case management. This can be accomplished by using theory-based evaluation methods where each component of the benefits counseling and case management intervention is mapped to potential outcomes and tested statistically or by using a case-based approach.

Motivational Interventions

Fear of losing benefits and negative belief systems continue to be a barrier to employment. The prevalent belief of beneficiaries and recipients that being eligible for SSDI or SSI I payments means they are ineligible to work is a persistent barrier to seeking employment. Similarly, motivation to return to work is a strong predictor of return to work. Benefits counselors could be engaged to provide motivational interventions that address beneficiaries' and recipients' negative thought processes and belief systems. For example, benefits counseling could be combined with motivational interviewing or cognitive behavioral therapy techniques to address negative belief systems about inability to work. Similarly, including a plan for actionable change using principles of behavioral economics could be tested. The use of actionable goals is supported by some preliminary evidence from PROMISE and AB Plus. SSA has recently announced that it will conduct an Exits from Disability study, which plans to incorporate motivational interviewing for a sample of SSDI beneficiaries and SSI recipients who exit SSA disability programs because they experience medical improvement.

Acknowledging and Evaluating Work Behaviors Based on Career Trajectories of SSDI Beneficiaries and SSI Recipients

Evidence from VR employment counseling suggests that the pathway to economic self-sufficiency is not linear, especially for individuals with severe limitations. The journey to economic self-sufficiency occurs in intermittent phases,

through participation in apprenticeship, temporary or seasonal work, part-time work, shadowing, temporary staffing, gig work, and so on (Kosciulek 2004). SSDI beneficiaries and SSI recipients who are re-entering the workforce might need several years to re-establish and stabilize themselves in a job and seek higher earnings through increased hours or career advancement. Short-term follow-up studies within the timeframe of 6-18 months might not capture these longer-term outcomes.

Youth with disabilities, who are transitioning to employment, could do so by engaging in internships, apprenticeships, and temporary jobs. Policymakers might consider embedding benefits counseling within programs that target internships or apprenticeships as an early intervention approach for youth in transition. Because apprenticeships and internships are an important milestone experience for youth with disabilities, embedding benefits counseling within them could build awareness early on and set youth on a trajectory for long-term economic self-sufficiency (Iwanaga et al. 2021). There is some evidence supporting the effect of benefits counseling on transition-age youth; future demonstration efforts could be focused on implementation or scaling-up of such services rather than on additional effectiveness or impact evaluation.

The nature of the jobs undertaken by SSDI beneficiaries and SSI recipients should be considered as a potential confounding variable. Beneficiaries and recipients who are employed in jobs that offer a natural pathway or trajectory up the career ladder could have greater potential for increasing earnings through career self-management and advancement. For example, beneficiaries and recipients who work in small businesses with limited staffing needs and positions might not have opportunities to advance in the short term. A vast majority of individuals with disabilities do not have any opportunity to engage in mentoring and career planning (Kulkarni and Gopakumar 2004).

Benefits counseling and case management could be supplemented by career planning and coaching services once a beneficiary or recipient is successfully placed in a job. Career planning and advancement is a process of adjustment an individual goes through to achieve satisfactory job performance and growth (King 2004; Kossek et al. 1998; Kulkarni and Gopakumar 2014). Sustaining and advancing in a job requires active planning and participation in the form of developing new job skills, networking, seeking feedback and advice, and developing insights into one's own career performance and aspirations (Claes and Ruiz-Quintanilla 1998; Kulkarni and Gopakumar 2014; Seibert, Kraimer, and Crant 2001). Sustaining or advancing in a job requires a different set of skills than does getting hired or placed in a job and a different type of case management and follow-up.

SSI recipients and SSDI beneficiaries might benefit from an extended model of support that does not end with benefits management or job placement but rather extends to career coaching for advancement and growth. For example, sustaining in a job requires demonstrating consistent work ethics, social interaction skills, and adequate time and task management. Advancing at work requires demonstrating

initiative, handling additional job task responsibilities, and self-advocating. Beyond job placement services, SSA might consider mentorship or coaching programs that support development of these behaviors at work. Future SSA demonstrations could consider conducting outreach to employers, human resource management professionals, and business leaders to facilitate work behavior outcomes that are consistent with developmental patterns in career trajectories of workers with disabilities.

Duration of Follow-Up

Retaining employment and increasing earnings potential for employed beneficiaries and recipients could take several years. The short duration of demonstrations makes it challenging to observe any long-term or distal outcomes such as those. Tremblay et al. (2004, 2006) used a four-year time frame following benefits eligibility determination to demonstrate improvements in employment status and wages earned. A longer follow-up duration might allow sufficient time for some of these career development activities to transpire. Such long-term follow-up activities can extend beyond the life of the demonstration itself.

Mediating Role of Work Incentives

SSI recipients and SSDI beneficiaries rely on a wide range of supports to sustain and advance in their jobs. The use of federally funded work incentives such as impairment-related work expenses or Plan to Achieve Self-Support can vary over the course of a beneficiary's or recipient's work life. Further longitudinal investigation of the timing and intensity of such services as mediators of the use of workplace accommodations and advancement could reveal new trends in how beneficiaries achieve self-sufficiency (Iwanaga et al. 2021).

Financial Literacy Training

Reaching economic self-sufficiency requires both income generation and asset building. Current SSA programs focus on income generation through finding and maintaining employment. Asset building by saving for emergencies and unforeseen circumstances can be considered a complementary strategy for reaching economic self-sufficiency. SSI recipients and SSDI beneficiaries have access to ABLE accounts to save for expenses related to living with a disability such as purchase of assistive technology, payments for housing, accessible transportation, and the like. In general, savings in ABLE accounts do not affect eligibility for SSI, Medicaid, SNAP, and the like.

Financial literacy training combined with benefits counseling can provide beneficiaries, recipients, and their families with tools to demystify the larger picture of economic self-sufficiency. Families and individuals with low incomes may lack the necessary financial literacy skills required to make informed financial choices.

Coaching financial literacy skills such as budgeting and money management can help beneficiaries and recipients feel more secure about their economic well-being and, in the long term, build assets. Access to financial literacy training that will propel individuals to save money in the long term is another way beneficiaries and recipients can build assets and become more economically secure. Though financial literacy training is included in some SSA demonstrations, an increased emphasis on the same and rigorous evaluation of the impact of such training will add to the existing knowledge base on this topic. Financial literacy training has its limitations, however; it may not be relevant to families who do not have the financial means to save.

Targeted Case Management Services

There is moderate to strong evidence from empirical research including SSA demonstrations that case management is an effective practice when implemented with high fidelity. Case management is especially effective in improving employment outcomes for individuals with mental health conditions. Case management offered within the context of high-fidelity supported employment programs also has been demonstrated to be effective for them. Data from Project NetWork highlights the cost-prohibitive nature of such services. Future implementation of case management targeted to a section of the beneficiary population who are at high risk for not returning to work or are least job ready could be a fiscally responsible approach.

Embedding Services in Integrated Health Systems

In the United States, health care and long-term services/supports have historically been delivered through separate and siloed channels. Health care organizations provide medical care whereas community-based organizations provide services that address social determinants of health factors (transportation, caregiver supports, Meals on Wheels, etc.). The Administration for Community Living (2020) has recently engaged in strategic planning to integrate health care and social services for individuals with disabilities and for older adults. Future SSA demonstrations could consider embedding employment support services within integrated programs to address health care needs and social determinants of health. For example, ACT programs provide integrated health and social services to individuals with mental health issues. Commonly referred to as the *hospital without walls* approach (Dixon 2000; Ellenhorn 2005), ACT teams deliver health and social care in integrated teams in the community rather than in residential hospital settings. A similar strategy could be used to embed benefits counseling and case management within integrated health and social service teams.

CONCLUSIONS

Many Americans with disabilities are striving to work and overcoming barriers to reach economic self-sufficiency. Benefits counseling and case management have been

characterized as essential services to assist them to return to or seek employment. However, evidence supporting the impact of these strategies on improving work outcomes and earnings for SSI recipients and SSDI beneficiaries is, at best, weak to moderate. This could be a function of the heterogeneous nature of the population targeted, variations in the content and structure of benefits counseling and case management programs, or duration and intensity of services provided.

Based on the available evidence, it is challenging to disentangle the unique impact of benefits counseling or case management from other services that were provided as part of SSA demonstrations. Outcome and impact evaluations reported by most SSA demonstrations consolidate and comingle multiple services. Future SSA demonstrations should clarify the scope, intensity, and frequency of benefits counseling and case management and examine their unique impacts through long-term follow-up studies.

Contributor

Vidya Sundar, Associate Professor of Occupational Therapy, University of New Hampshire—Dr. Sundar's current research focuses on intervention programs for career development and sustainability for individuals with disabilities.

Chapter 8

Comment

John Kregel
VCU National Training and Data Center
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Dr. Sundar (in "Benefits Counseling and Case Management") provides an excellent analysis of the use of benefits counseling as a component of Social Security Administration (SSA) demonstrations. She documents the differences between benefits counseling in early 2000s demonstrations, such as the State Partnership Initiative (SPI), which occurred as SSA was launching the Benefits Planning, Assistance, and Outreach (BPAO) program, and later demonstrations, such as the Benefit Offset National Demonstration (BOND) and Promoting Opportunity Demonstration (POD), which were developed to be comparable to the current Work Incentives Planning and Assistance (WIPA) model. The WIPA model was redesigned by SSA in 2006 in response to shortcomings in the BPAO program and prioritizes the delivery of benefits counseling to SSDI beneficiaries and SSI recipients who are employed or have a job offer pending (Kregel and O'Mara 2011).

Including benefits counseling services in demonstrations in a manner similar to those in the WIPA program provides support to the treatment group participants throughout the intervention and enables SSA to assess the feasibility of widespread implementation of policy changes or program waivers. The comments below describe:

- the importance of high-quality benefits counseling services in SSA demonstrations; and
- strategies that should be used to standardize benefits counseling interventions in multi-site demonstrations.

IMPORTANCE OF BENEFITS COUNSELING IN SSA DEMONSTRATIONS

As described in Chapter 8, benefits counseling services are often combined with other interventions in SSA demonstrations. In some demonstrations, such as SPI and Promoting Readiness of Minors in Supplemental Security Income (PROMISE), the design allowed variation across sites in the job descriptions of benefits counselors and the manner in which benefits counseling was combined with other interventions. This approach enabled individual sites to develop interventions that responded to the needs of participants and the unique characteristics of the state/local service delivery system, but limited the extent to which results could be combined across sites.

In contrast, in the BOND and POD projects, SSA designed the benefits counseling intervention to be comparable to the WIPA program. The design established specific performance measures that required all benefits counseling services to meet basic quality standards. Though a proposed policy change, such as the gradual benefit offset

in BOND and POD, may seem simple and straightforward, SSA conducts demonstrations in the context of a highly complex regulatory system. Benefits counselors must be able to assist beneficiaries to navigate the SSDI program rules addressing the effect of increased earnings on benefit amounts and program eligibility, use of work incentives, relationship between work and continued health care coverage, availability of other federal and state-specific benefits, and the unique situations of concurrent beneficiaries and self-employed individuals.

In summary, if benefits counselors deliver inaccurate or incomplete information to demonstration participants, it can have negative consequences for SSDI beneficiaries and SSI recipients. Effective benefits counseling requires work incentives counselors to possess a combination of detailed technical knowledge, high-level counseling skills, and ability to accurately describe complex information to beneficiaries and recipients in a way that will enable them to make confident decisions about their careers and health insurance coverage. The development of rigorous performance standards for the delivery of benefits counseling services should continue to be the standard for future SSA demonstrations that test new policies or programs.

STANDARDIZING BENEFITS COUNSELING INTERVENTIONS IN MULTI-SITE DEMONSTRATIONS

Designing and implementing effective benefits planning components of SSA multi-site demonstrations require the development of replicable service protocols, rigorous training for work incentives counselors, and continuous technical assistance to maintain service integrity. A lack of standardization can make it difficult to aggregate data across sites or assess the use of evidence-based or promising practices. For example, in the context of POD, standardization efforts focused on development and monitoring of service delivery protocols; rigorous training of work incentives counselors; and ongoing, intensive technical assistance.

Standardization of Service Delivery Protocols

The POD benefits counseling intervention was based on the development of SSA-approved service delivery protocols that cover the following service components: onboarding and engagement, earnings and benefits verification, counseling on the specific alternative rules of the demonstration, Benefits Summary and Analysis report preparation, referral for employment services and supports, and off-boarding (return to standard SSDI rules, if included as a part of the demonstration). In POD, ongoing monitoring of the implementation of these protocols made it possible to assess the effectiveness of the intervention across multiple sites.

Standardization of Work Incentives Counselor Training

All POD counselors not previously certified as work incentives counselors completed a formal, competency-based training program, based on rigorous

assessments, prior to beginning services. In addition, all counselors were required to complete a comprehensive training module addressing the rules and procedures specific to the demonstration.

Standardization of Technical Assistance

SSA required the POD implementation contractor to provide ongoing technical assistance to each individual site manager and individual work incentives counselors. Technical assistance included monthly webinars with site managers and work incentives counselors, semi-annual site visits to each site designed to enhance compliance with all service delivery protocols, and monthly calls with individual work incentives counselors to conduct case reviews on individual participants.

CONCLUSION

As documented in Chapter 8, variation in the delivery of treatment group interventions sometimes makes it difficult to aggregate data across multiple sites in SSA demonstrations. In designing the POD project, SSA sought to standardize treatment interventions across program sites by developing detailed service delivery protocols, providing rigorous training for demonstration staff, and monitoring site performance throughout all phases of the intervention. SSA's continued use of these standardization strategies can increase the overall fidelity of the interventions and promote the use of promising or evidence-based service practices in SSA demonstrations.

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Chapter 8

Comment

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Michigan United Cerebral Palsy

Over the past 40 years, the Social Security Administration (SSA) has conducted many demonstration projects that have incorporated benefits counseling and case management. For most of those demonstrations, the goal has been to identify ways to reduce reliance on benefits, decreasing participation in Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Although there has been a recent decline in participation, there continues to be a lack of meaningful changes in unemployment for people with disabilities. According to data from the US Bureau of Labor Statistics, in 2020 the unemployment rate for people with disabilities was at 12.6 percent, the highest in seven years.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) was signed into law to increase the options for individuals with disabilities who wished to return to work. Through the Ticket to Work program, benefits counseling was recognized as a core service for those receiving SSI and SSDI benefits. Benefits counseling has transitioned from the Benefits Planning Assistance, and Outreach (BPAO) program, which ensured beneficiaries and recipients were receiving accurate information, to the current Work Incentives Planning and Assistance (WIPA) program. WIPA focuses on providing benefits counseling to those who are working or have an active work goal.

One of the challenges with the WIPA program is funding. Programs in 2021 continue to be funded at the same level of the initial BPAO projects in 1999. The WIPA program was tasked by SSA to "disseminate accurate information to beneficiaries with disabilities…about work incentives programs and issues related to such programs." The ultimate goal of the assistance was to "assist SSA beneficiaries with disabilities succeed in their return-to-work efforts" (SSA 2006).

Over the years it has been difficult for WIPA to address *all* employment barriers faced by SSDI beneficiaries and SSI recipients with disabilities, such as work disincentives contained within SSA, overpayments and other benefit programs, employer reluctance to hire them, fears of losing health care, or lack of service providers to assist them in acquiring the skills they need to find and retain employment. What WIPA is able to address are the barriers to work due to beneficiaries' lack of understanding of work incentives or inability to connect with resources to support their employment.

The implications that Ticket to Work had for many SSI recipients and SSDI beneficiaries were major. The program has given them the opportunity to have greater control and choice of their path to work.

SSI and SSDI provide economic security for many who are living below the federal poverty level. After waiting many months, sometimes years, before being accepted to receive benefits, the idea of working is a scary reality for most. Many people are afraid to go to work or have the mindset that they cannot work that promoting employment and economic stability from the beginning of their participation in SSDI or SSI is a challenge.

Benefits counseling and case management have been critical components of SSA's demonstrations. From Dr. Sundar's discussion of the Benefit Offset National Demonstration, Promoting Readiness of Minors in SSI, State Partnership Initiative, Accelerated Benefits, Mental Health Treatment Study and Project NetWork, we discover that supporting various populations requires different approaches. Building trust and a working relationship are also critical.

Therefore, using a one-size-fits-all approach to supporting individuals receiving benefits will more than likely not gain positive results. We learned that incorporating a person-centered approach based on a person's individual circumstances will likely garner the best results. A person-centered approach is where the person is placed at the center of the service; the focus is on the person and what they can do, not on their condition or disability. Support should focus on achieving the person's aspirations and be tailored to their needs and unique circumstance.

There is ample evidence that incorporating case management works well for youth and those with mental health–related disabilities. We also know that navigation of the complex Social Security rules is very difficult for most. Trained benefits counselors are critical to provide much needed information. As Dr. Sundar discussed, some individuals, such as those with mental illness, are aided most by benefits counseling and case management paired with Vocational Rehabilitation (VR) services. She also concluded that case management might not be relevant for all beneficiaries and recipients.

If we place a greater emphasis on subpopulations and identifying what works and does not work, we will likely have a greater impact on service delivery. Dr. Sundar also indicated that financial literacy is another tool to promote self-sufficiency and that could instill the desire to work or return to work.

Timing is important in relationship to benefits counseling and VR services. For example, working with transition-age youth and incorporating benefits counseling as part of the transition plan will plant an early seed for youth who will soon be exiting the educational system, making the handoff to VR a more natural progression to independence. Similarly, encouraging SSDI beneficiaries and SSI recipients at the onset of receiving benefits that employment is an option and making benefits counseling available immediately can support their transition back to work.

It is promising that SSA continues to implement demonstrations that focus on incorporating case management and benefits counseling, but we need to take a deeper dive at the underlying issues surrounding unemployment and the disincentives of returning to work.

Leslynn R. Angel, President and CEO, Michigan United Cerebral Palsy—Ms. Angel has worked successfully at assisting individuals with significant disabilities find employment, utilizing customized employment. Her experience includes training Vocational Rehabilitation counselors and others and introducing choice-based philosophies and technology into the Vocational Rehabilitation system.

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