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**Pursuing an Integrated Demand and Supply Side Research Agenda at the State
Level: Musings on Potential Opportunities from Wisconsin**

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Introduction

In modern societies, the vast majority of paid employment involves a relationship between two parties: an employer and an employee. Generally, this relationship can be characterized as contractual, though in some cases the relationship may be structured, in part, by familial or other forms of non-contractual social relationships. Even self-employment can be viewed in this framework, as the self-employed individual performs functions and, at some level, has interests that are associated with each of the roles. To perhaps belabor the point, to talk about fuller incorporation of persons with significant disabilities into the labor market or to have better outcomes for those already participating involves increasing both the quantity and quality of employment relationships.

To tie this back to this meeting's theme, research that identifies the conditions that lead to better employment outcomes for those with disabilities must look at both sides of the employment relationship, whether the relationship is actual or, given current labor participation rates, more often potential. In the parlance of this meeting, there needs to be greater integration between the body of studies of "supply-side" phenomena (i.e., the preferences, barriers, incentives, assets, and limitations associated with workers or potential workers) and the body of "demand-side" studies (i.e., those focusing on the preferences, barriers, incentives, assets, and limitations associated with employers). I am not arguing that all research must focus explicitly on both sides of the relationship. Rather, I think those wanting to contribute to "nexus" research need to frame their efforts in ways that make it easier to make linkages between studies that focus predominately on either the supply or demand side. As a practical matter, given the relative lack of studies about the demand side of the relationship, it suggests the importance of increased efforts in that side to provide the raw material needed to facilitate a nexus research agenda.

My goal today is to apply these quite abstract musings to a specific context in the United States, that of state initiatives to increase employment outcomes among persons with disabilities that are supported by federal agencies through financial support and, sometimes, by allowing modifications or temporary suspensions of program rules and eligibility requirements. Though such initiatives can range from "permanent" changes in programs or policies to explicitly experimental demonstration projects, in all cases the state and federal partners hope to learn something from these efforts that can be more broadly applied. It is reasonable to examine to what extent these initiatives have been designed to promote "systems change" that would touch both workers and employers or what needs to be done to encourage federally supported state initiatives that would do so. Similarly, it is reasonable to look at what has been or could be done to utilize such opportunities in order to pursue a nexus research agenda.

About Wisconsin

I will not pretend to be knowledgeable about the full range of such efforts across the United States or even in Wisconsin, the state where I work. Instead, I focus on the set of initiatives associated with one agency, the Office of Independence and Employment (OIE) in the Wisconsin Department of Health and Family Services (DHFS). OIE has minimal responsibilities

for ongoing program operations; it is mainly a unit constituted to develop and test, most often in collaboration with other entities, new approaches for increasing the rate of competitive employment among persons with disabilities and the earnings and other outcomes associated with such employment. OIE's general approach toward achieving these ends is through capacity building and technical assistance activities aimed at expanding good practice.¹ To perform its primary functions OIE must give substantial attention to learning from its efforts and has utilized both internal and external capacity to do so.

It is important to note that DHFS is Wisconsin's Medicaid agency. The department's and, consequently, OIE's concern about issues of disability and employment is largely framed in the context of Medicaid eligibility, current or potential. Thus, the population of most direct concern is that composed of persons who meet or may be found to meet eligibility criteria essentially the same as those for the Social Security disability programs.² Though comparisons of different standards or conceptions of disability pose some ambiguity, it is generally agreed that the SSA disability criteria captures a population facing greater barriers, both endogenous and exogenous to full labor market participation, than the populations who meet other US government recognized definitions of disability.

Wisconsin has one of the largest and oldest Medicaid Buy-in programs, a program advocated for and largely developed by OIE.³ Additionally, OIE administers the state's very large Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services (CMS) and has been involved in the planning or implementation of multiple Social Security Administration sponsored pilots.⁴ Over the past decade, funding, waivers, and demonstration

¹ OIE is the current name for the work unit. OIE's origins was as part of an entity created to plan a major redesign of the DHFS system for providing long term care services to the elderly and those with disabilities. What was to become OIE coalesced around the design and implementation of Wisconsin Pathways to Independence, one of SSA's State Partnership Initiative demonstration projects. Indeed, most of OIE's activities are still referred to as the Pathways Projects, both recognizing this history's continuing relevance and the fact that most persons staffing OIE are University of Wisconsin system, not DHFS, employees.

² As in most states, SSI recipients in Wisconsin are automatically eligible for Medicaid. In any case, adults under 65 seeking to establish Medicaid eligibility for reason of disability must meet the Social Security disability standard as well as other economic or behavioral criteria associated with the specific Medicaid eligibility category.

³ Wisconsin's Medicaid Buy-in program, the Medical Assistance Purchase Plan or MAPP, is in the category of such programs authorized by the 1997 Balanced Budget Act. Though fully separate from Wisconsin's SSA sponsored State Partnership Initiative demonstration, the expectation was that MAPP would allow SSDI beneficiaries with the capacity to earn above the SGA level to permanently leave benefit status by assuring them access to health care through the Medicaid program.

⁴ The 2008 MIG award is nearly \$7 million. OIE, as will be described, uses this funding to undertake an extensive range of capacity development activities. Efforts in cooperation with SSA include participation in the State Partnership Initiative (SPI) and the SSDI Cash Benefit Offset Pilots. OIE also participated in

authority from CMS and SSA has allowed OIE (and its partners) to develop and (usually) test multiple approaches to improving employment outcomes for persons with disabilities and to support and sustain the expansion of approaches that seemed to have promise.

Nonetheless, the lion's share of these efforts must be described as "supply-side" interventions. The following list is of approaches, rather than of specific initiatives. Though far from complete, it will give a sense of the substantial diversity of OIE's activities, but also of their disproportionate focus on supply-side issues:

- Training and technical assistance to support expansion and improvement of work incentive benefits counseling
- Policy development of the Medicaid Buy-in, for enhancements to the Buy-in, and for Medicaid waivers.
- Integration of benefits counseling and person centered planning in a single service delivery model
- Incorporation of person centered planning and/or self-directed services into a developing managed care (capitated) system for delivering long term support services
- Testing benefit offset provisions or enhancements to existing benefit offset programs
- Developing efforts to teach self-advocacy skills or resources to promote this (e.g., an online benefits' calculator)
- Developing service strategies and toolkits to support program development in specific areas, such as transportation or personal assistance services
- Stigma reduction training or outreach efforts
- Efforts to build communities of practice among professionals serving persons with disabilities
- Building community or regionally based entities to identify needs, potential solutions, and build support for action
- Efforts to facilitate asset building and/or self-employment
- Developing resources that allow employers to seek information and resources on an individualized basis

Many of the items on this list certainly have connections to demand side subject matter. For example, a toolkit intended to help consumers or government officials expand the

planning activities for the aborted Early Intervention Pilot Project and for the upcoming Benefit Offset National Demonstration.

availability of transportation to, among other locations, workplaces, may also serve employer needs. Similarly, helping potential workers develop self-advocacy skills may help employers better identify appropriate and cost-effective work accommodations and supports. Nonetheless, only the last item on the above list is unequivocally consistent with demand side interventions.

Of course, the strong tendency for OIE to pursue interventions chiefly on the supply side is hardly surprising. Most government entities with social service responsibilities have been client (increasingly “consumer”) focused, if not always responsive to those putatively served.⁵ Pursuing supply side strategies has certainly been the dominant tendency for DHFS programs, especially those Medicaid or long term support related. Closely related is the fact that programmatic definitions of disability have more strongly focused on the characteristics of those served, giving less attention to the interaction between any individual’s impairing condition and the environment in which the individual lives.

However, DHFS has always engaged in what can be rightly termed demand side activities as part of implementing Medicaid and related programs that serve persons with disabilities. Such activities arise from the fact that most Medicaid and long term care services are delivered through non-governmental entities and that, consequently, DHFS has fiduciary responsibilities to both consumers and the public. Some obvious examples of these activities are claims payment, fiscal monitoring, quality assessment, licensure/certification, and, increasingly, setting capitation rates. It is also true that DHFS has undertaken various capacity building and technical assistance activities in support of the delivery of Medicaid and long term care services and that the extent of such activities appears to have increased over, at least, the past decade.

Thus, to the extent that OIE as a capacity building unit undertakes initiatives with significant demand side components and goals, it would be engaging in activities that could be viewed as logical extensions, rather than major deviations, from recent DHFS practice. The main difference would be a stronger emphasis on acting in ways more congruent with the self-identified goals and interests of private sector economic units. This emphasis could be seen as paralleling the greater attention given to consumer identified goals, interests, and, often, control over the services they receive through government.⁶ In turn, such demand side activities open

⁵ The use of the term “client” is deliberate to connote the traditional relationship between government service programs and the relatively disadvantaged and politically powerless citizens served. Like many public agencies serving such populations, DHFS has increasingly shifted to calling those it serves consumers and restructuring program delivery in ways more consistent with the concept of choice that being a consumer implies. Both the long term care redesign (i.e., Family Care) and OIE’s activities reflect this shift. Thus, for the rest of this paper the term “consumer” will be used instead of “client.”

⁶ No claim is being made that government should give precedence to the choices of individuals or private entities, only that in recent years such values have become more fully incorporated into governmental activity and public discourse. The extent that market principles should replace or augment those of traditional democratic governance is an area of ongoing political struggle.

up new opportunities for learning, whether in the form of OIE staff identifying good practice or through formal research activities.

Two Cautionary Examples

As discussed, little of OIE's activity can be characterized as demand-side. Consequently, both internal assessments of these activities and more formal examinations carried out by external parties have had a largely supply-side orientation. So to explore the potential value of greater supply-side and demand-side research integration, I will use two examples from a research effort I lead. The examples are drawn from an interim evaluation report of a supply-side initiative, the Wisconsin SSD Employment Pilot (SSDI-EP).⁷ The SSDI-EP is one of four state based pilots that the Social Security Administration has authorized to prepare for a national demonstration testing the work incentive effects of a cash benefit offset. SSDI-EP participants are volunteers. Those randomly assigned to the treatment group lose one dollar of their SSDI benefit for every two dollars in earnings above the SGA level.⁸ By contrast, those in the control group lose their entire cash benefit when they earn above SGA, consistent with current law.

My first example stems from participant responses to a survey item: "If I work for pay, it will be hard to earn enough money to make up for lost Social Security benefits." This item was first asked at the time each participant entered the SSDI-EP and did not yet know whether he/she would be assigned to the treatment group. The item was asked again approximately one year later. One expectation was that the response pattern would be more or less the same for both treatment and control group members at project entry. The second expectation was that one year after entry those in the treatment group would more strongly disagree with the item than those in the control group, as treatment group members were both told and given written information about the offset provision at enrollment and had ongoing access to work incentive benefits counseling if they wanted further clarification of the offset provision. A third expectation is that those who actually used the offset provision would disagree even more strongly with the question based on their experience using the offset.⁹

Table one presents the results. "C" denotes the control group, "T" the treatment group, and "O" those members of the treatment group who had actually used the offset provision by the

⁷ This report is not, at the time of writing, available to the public. However, the material present below can be obtained in the following: Delin, Barry S., Hartman, Ellie, C. and Sell, Christopher W., "Impacts Associated with the Wisconsin SSDI Employment Pilot: Participant Outcomes, Perceptions, and Experiences." unpublished manuscript. 2008. This material can be obtained by contacting the lead author at delinb@uwstout.edu or 608-261-7813.

⁸ The offset was applied only after completion of the Trial Work Period and of the three month "grace period" following completion.

⁹ Only 17% percent of those in the treatment group completing both their baseline and year one follow-up surveys had actually used the offset by the end of their first year of participation. Given the small number of responses (36), results for this subgroup should be viewed as provisional.

time they responded to the follow-up survey. A subscript of “0” identifies baseline survey results; “1” identifies results from one year after SSDI-EP entry.

Table 1: Responses to Survey Item: in Percentages, Baseline and First Annual Follow-Up Surveys, “If I work for pay, it will be hard to earn enough money to make up for lost Social Security benefits.”

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Sure
T ₀	9.1%	8.2%	14.9%	17.9%	38.5%	11.5%
C ₀	9.1%	10.8%	15.9%	16.5%	38.6%	9.1%
O ₀	8.3%	5.6%	13.9%	19.4%	44.4%	8.3%

T ₁	9.1%	11.0%	14.4%	14.8%	41.6%	9.1%
C ₁	10.3%	2.9%	8.6%	14.9%	56.3%	6.9%
O ₁	5.6%	22.2%	16.7%	19.4%	36.1%	0.0%

Source: SSDI-EP Participant Surveys

Note: C=176, T = 212, O = 36.

As expected, given random assignment, all three groups’ responses were similar at pilot entry. Also as expected, given current law, all respondent groups tended to agree with the statement. What was not expected is that the treatment and control groups’ responses did not diverge a great deal after one year. Both groups, on average, became more doubtful of the likelihood that they could earn enough to make up for the loss of SSDI benefits.¹⁰ While it is true that those who used the offset became more optimistic about their ability to come out ahead financially, the change in the distribution appears to be mainly the result of movement out of the “not sure” response category.

When I saw these findings, my thinking about likely explanations were chiefly on the supply-side. For example, I knew that participant attitudes and perceptions about the SSDI program were likely to be deep seated. I was aware how difficult it is for many beneficiaries to establish their eligibility. I also knew that the consequences of losing the cash benefit or, ultimately, program eligibility would usually be serious. Beneficiaries have good reason to be risk adverse. I also knew that SSA’s implementation of the offset provision had not been

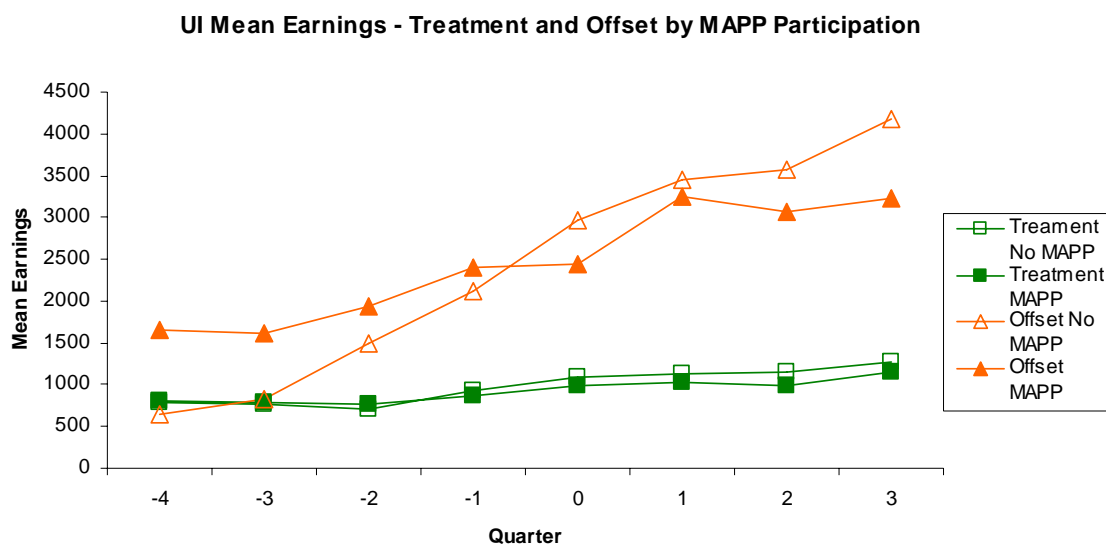
¹⁰ While those in the control group exhibited a somewhat greater shift in their answers in the direction of being more doubtful that earnings could make up for lost SSDI benefits, this result stems mainly from the fact that the responses for the offset users are included in those for the treatment group as a whole.

smooth. Problems with the timeliness or accuracy of checks had not been merely common, but ubiquitous.

Though I still think that such supply side factors are likely to explain most of what I observed, preparing for this conference may me more aware of the possibility that demand-side factors may have had some role in producing the observed patterns. It is quite possible that participant responses were informed by their perceptions and experiences in the labor market, including those that occurred subsequent to project entry. These perceptions and experiences may be “conditioned” to some degree by what employers think, how they act, and the impact of both market conditions and regulatory requirements upon both thought and action. However, and this is the key point, I hadn’t paid attention to this possibility in my survey design or in my other research planning. While there was nothing in SSA’s evaluation requirements that demanded I do this, there was nothing that prevented it except my own failure to anticipate any significant value in doing so.

At risk of unnecessary repetition, I offer a second example. Chart one displays mean earnings (from unemployment insurance records) for a period starting four calendar quarters prior to project entry through three quarters after. In this chart, only findings for the treatment group and offset users are displayed. There are two trend lines for each of these groups based on whether they use another work incentive, the Medicaid Buy-in (MAPP).

Chart 1: UI Mean Quarterly Earnings in Constant Dollars Q-4 through Q3 for the Treatment Group and Known Offset Users, Based on MAPP Participation Status in the Enrollment Quarter



Source: Wisconsin UI Records and Wisconsin Medicaid Records

Note: T w MAPP = 113, T w/o MAPP = 152, O w MAPP = 15, O w/o MAPP = 25

The most obvious finding is that there is a large and growing difference between mean earnings for those in the treatment group who have used the offset and those who didn't. However, for this discussion there is a more important finding. Though MAPP is designed as a work incentive, the apparent effect is small and in the "wrong" direction. In both the overall treatment group and among the offset users those participating in the Buy-in tend to have lower average earnings, particularly in the time period following enrollment in the SSDI-EP. Once again, I sought possible explanations on the supply-side. Yet, it is also possible that demand-side phenomenon, such as the availability of jobs or the terms of that availability in the labor market may have a significant role in explaining the observed findings. However, mea culpa again! I had not anticipated the potential value of building into the evaluation plan the resources that would allow me to look at demand-side explanations.

Implications

It is beyond my skill to identify specific steps for integrating demand side concerns or variables into every research design. Additionally, though I have suggested the utility of having greater awareness of the value of either incorporating demand-side variables as part of supply-side research and/or of consciously looking for linkages between supply side and demand side phenomena, I think it more important to identify contexts supportive of pursuing "nexus" research. Again my emphasis is on the states. Again my thinking is informed by the Wisconsin experience.

Approximately forty states currently have Medicaid Infrastructure Grants (MIGs). Many of these grants are small "basic" grants, mainly for the purposes of planning or implementing a Medicaid Buy-in and/or increasing the availability of personal assistance services that can be used to support employment. However, CMS has awarded a smaller (though growing) number of the much larger "comprehensive" grants, including one to Wisconsin.

States are expected to use their comprehensive grants to promote systems change that in turn is expected to result in better employment outcomes for those with disabilities. With a limited exception for benefits counseling, monies cannot be utilized for direct service provision. Infrastructure development is conceived broadly, both as to the type of initiatives permitted and to the populations served. Though CMS has never explicitly identified the boundaries of the population to be benefited through MIG supported activities and initiatives, it is clearly broader than current Buy-in participants or those eligible for Medicaid for reason of disability, including, but not limited to, SSDI beneficiaries and SSI recipients. Specific objectives mentioned in the 2008 grant solicitation are identified in the context of what is termed the development of a comprehensive employment system and include:

- Maximizing employment for people with disabilities
- Increasing the State's labor force through the inclusion of people with disabilities

- Protecting and enhancing workers healthcare, other benefits, and needed benefits, and needed employment supports¹¹

Although every one of the comprehensive MIG's goals can be pursued through supply side initiatives, the same observation can be made for demand side initiatives. However, as CMS and, ultimately, Congress which authorized the MIG program, is seeking system change, it follows that both types of initiatives are needed. As posited at the outset of this paper, employment involves a relationship between two parties – an employer and an employee.

CMS requires states receiving comprehensive grants to develop strategic plans to guide the development of both the specific initiatives and how those initiatives will support systemic change.¹² Wisconsin developed its plan through a process that gathered input and sought consensus among a broad range of stakeholders, including employers and business organizations. Four of the six priorities identified through the strategic planning process explicitly identify both employers and consumers as the joint focus of the priority.¹³

However, through the 2008 grant year, MIG funded initiatives remained mainly on the supply side. The most important exception has been WorkSource Wisconsin, a resource and information center housed at University of Wisconsin – Stout designed and operated with substantial input from the business community. There have been other, less direct efforts to use the MIG to foster demand side initiatives. For example, the MIG is being used to support the development of broad regional coalitions and an associated competitive grant program involving both disability stakeholders and those more directly concerned with broader issues of economic and community development. The geographical boundaries of these regions were chosen to match those of Wisconsin's main economic development initiative.

As I write OIE is developing its MIG funding submission for 2009-11, the final years for which Congress has authorized the MIG program. If Wisconsin's proposal is in accordance with its strategic plan, there will be an increasing emphasis on initiatives that are either directly demand side or have some component that speaks to employer needs and interests. If this proves true (and OIE has a track record of having each successive MIG submission more closely align with the strategic plan), there will be more subject matter appropriate for nexus research, including that on the progress Wisconsin has made toward genuine system change. OIE can help promote this by insisting on both internal assessment and more formal research

¹¹ 2008 Edition-Announcement, Medicaid Infrastructure Grant, To Support the Competitive Employment of People with Disabilities, HHS-2008-CMA-MIG-0001. 2007. Baltimore, MD: Center for Medicaid and State Operations, The Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. pp. 5-6.

¹² 2008 Edition-Announcement, Medicaid Infrastructure Grant, To Support the Competitive Employment of People with Disabilities, HHS-2008-CMA-MIG-0001. 2007. p. 12.

¹³ "Communities that Work: The Wisconsin Pathways to Independence Plan." 2006. Madison WI, OIE/DHFS (brochure).

activities that look at outcomes and what constitutes good practice from both the consumer/employee and employer perspectives.

Finally, I want to briefly comment on what federal agencies can do to support the development of nexus research on the state level. Obviously money matters. It is important that programs like the MIG continue. However, there are other ways in which federal agencies can encourage nexus research. Federal agencies can provide technical support on behalf of both program development and research. For example, in the context of the MIG, CMS has supported the creation of free standing technical assistance centers that are highly responsive to state defined needs, as well as providing its own direct assistance and oversight.¹⁴ These efforts can be increasingly focused on encouraging and supporting programming suitable for nexus research as well as such research itself. Indeed, two of the general principles that are expected to guide the activities of states with comprehensive grants are that:

- There must be a mutual benefit to the employee with a disability and the employer.
- and
- Local labor market (employer) needs must be met.¹⁵

Secondly, federal agencies can encourage state grantees to actively share what they have done and what they have learned. CMS has facilitated this, though, to date, there has been less emphasis on demand side issues than might be desirable with an increased focus on nexus issues.

Finally, federal agencies can support states' efforts to learn as a primary goal, even if that means that states sometimes learn what doesn't work. In my opinion, CMS has generally pursued this course in regard to the MIG. Indeed one of the directives for the MIG comprehensive states is quite literally to do "whatever it takes" to achieve better employment outcomes.¹⁶ Though others may interpret this directive differently, I view this as instruction from CMS to learn as much as possible. Though achieving better employment outcomes must remain the ultimate goal, my hope is that CMS continues to place high value on such learning.

¹⁴ For example on the policy and program development side, CMS supports the National Consortium for Health Systems Development. On the research side, CMS supports the Medicaid Infrastructure Grant Research Assistance to States (MIG-RATS). MIG-RATS has limited access to the resources of Mathematica Policy Research, Inc. which also holds a contract for the national evaluation of MIG and other Ticket to Work related efforts.

¹⁵ 2008 Edition-Announcement, Medicaid Infrastructure Grant, To Support the Competitive Employment of People with Disabilities, HHS-2008-CMA-MIG-0001. 2007. Baltimore, MD: Center for Medicaid and State Operations, The Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. p. 10.

¹⁶ 2008 Edition-Announcement, Medicaid Infrastructure Grant, To Support the Competitive Employment of People with Disabilities, HHS-2008-CMA-MIG-0001. 2007. p. 11.

This practice is, I think, highly desirable in that the MIG largely involves capacity building rather than direct service and even the largest MIG funded initiatives are of modest scale compared to the size of the population that might benefit. By implication, I hope that other federal agencies will adopt or continue to act from a similar perspective.