



# Timing of Medicaid Enrollment for Children Engaged with Child Welfare Services in Two States

Brett Greenfield

## KEY POINTS

This brief examines the timing of Medicaid and Children’s Health Insurance Plan (CHIP)—hereafter, “Medicaid”—enrollment relative to timing of engagement with child welfare services for children in Florida and Kentucky. The analysis covers children involved in child welfare systems from 2017-2021. Medicaid funds essential health and behavioral services for children from low-income families, including services that can prevent the need for child welfare engagement. Understanding how and when families engage with multiple public systems can help improve the utility of these programs for families and inform the policies that help families access the supports they need.

- Close to two-thirds of children were enrolled in Medicaid before or at the time of their earliest child welfare report.
- Black and White children were most likely to be enrolled in Medicaid prior to child welfare reports compared to other racial groups.
- Younger children are more often enrolled in Medicaid prior to being reported to child welfare than older children.
- Children with disabilities were less often enrolled in Medicaid prior to child welfare report.
- Medicaid coverage prior to child welfare involvement was higher among children with reports of neglect and medical neglect, compared to other maltreatment types.
- These results suggest areas for further research, specifically in understanding how utilization of Medicaid-funded services changes before and after involvement in child welfare systems.

## INTRODUCTION

A large proportion of children and families who receive child welfare services are eligible for Medicaid. Medicaid enrollment provides access to health services to low-income children and adults, which is particularly important for families at risk of engagement with child welfare systems. As many as 2 out of every 5 children in the U.S. are enrolled in Medicaid, and 4 out of 5 children living in poverty are enrolled.<sup>i</sup> Participation rates for children on Medicaid (i.e., the proportion of children eligible for Medicaid who are enrolled) vary across years and states. In Florida, the 2019 participation rate was 90.6 percent, a 2.2 percent decrease from 2016-2019.<sup>ii</sup> In Kentucky—a state that expanded Medicaid—the 2019 participation rate was 94.3 percent, a one percent decrease from 2016-2019.<sup>iii</sup>

Medicaid eligibility and enrollment for children and families is influenced by numerous federal and state policies. For example, in 2013 the Affordable Care Act (ACA) authorized Medicaid expansion to increase eligibility for Medicaid among adults. This policy was important for families at risk of child welfare engagement as research shows that when parents receive Medicaid coverage, they are more likely to enroll their children in eligible coverage as well.<sup>iv</sup> Parental Medicaid, enhanced by 12-month post-partum

coverage extensions, also enables parents to access services including treatment for mental illness and substance use disorders that may be related to their child welfare involvement. Additionally, since the enactment of the Family First Prevention Services Act of 2018 (P.L. 115-123) (hereafter FFPSA), many states have implemented mental and behavioral health services to prevent child welfare engagement, using multiple funding sources included Title IV-E and Medicaid funds.<sup>v</sup> Because the funding streams for child welfare service payments via Medicaid or Title IV-E prevention dollars can be complex, there is an imminent need for increased coordination between Medicaid and child welfare systems.

A first step in understanding the coordination needed to effectively deliver child welfare prevention services with Medicaid support is to identify which children are enrolled in Medicaid before or after the onset of child welfare engagement. Therefore, this brief aims to use data collected from the Child and Caregiver Outcomes Using Link Data (CCOULD) project to assess the timing of children’s Medicaid enrollment relative to the onset of their child welfare involvement. Further, we assessed the differences in enrollment trends by various child demographic and child welfare case characteristics to identify possible groups less likely to receive Medicaid funded child welfare prevention services. This research is limited to children who were successfully enrolled in Medicaid before or after onset of child welfare engagement, but was unable to assess whether these children were eligible for Medicaid prior to child welfare engagement.

## DATA AND METHODS

To assess the timing of Medicaid enrollment relative to reporting to child welfare, this research analyzed data from the Child and Caregiver Outcomes Using Link Data (CCOULD) project. CCOULD provided technical assistance to two states – Kentucky and Florida – in linking their Medicaid administrative claims of children and their caregivers with case-level data from the child welfare system. CCOULD then combined state-specific datasets by mapping them onto a common data model and created a multi-state, deidentified dataset for secondary data analysis by researchers. ASPE has published previous [work](#) describing the objectives and approach to CCOULD, as well as lessons learned from the project.<sup>1</sup> This dataset is comprised of data on over one million children and their caregivers engaged with both child welfare and Medicaid services between 2017 and 2021 in Florida and Kentucky. This research is limited to children with both child welfare and Medicaid records, which included approximately 80% of children identified as having a child welfare report.<sup>vi</sup> For Medicaid records, we relied on enrollment information for children, but did not have information about their Medicaid eligibility status. Child welfare reports include both substantiated and unsubstantiated maltreatment reports, as well as children placed in foster care, and those that remained with caregivers of origin. Additionally, some children may have been reported to child welfare, but never received child welfare services. The information derived may not be representative of child welfare engaged populations across the U.S. Details on the variables, structure, data quality, and other documentation are available through the [National Data Archive on Child Abuse and Neglect](#) (NDACAN).<sup>2</sup> Using linked administrative data affords this research the ability to examine the experiences of individuals engaged in multiple-overlapping service systems.

For this analysis we restricted data to children with complete administrative data records for key outcome variables of child welfare report date and Medicaid enrollment dates across child welfare and Medicaid data systems, which yielded a final sample of 975,415 children. These data are complex and require linking child welfare and Medicaid records across multiple data files. Information about data cleaning and defining key variables is provided in Appendix A.

In this brief, we provide the demographic and case characteristics of the sample, and compared children’s earliest Medicaid enrollment date to their earliest child welfare report date to determine whether children were enrolled in Medicaid at the time of child welfare report. We also assessed differences in Medicaid enrollment trends by demographic and case characteristics using one-way analysis of variance. All

---

<sup>1</sup> <https://aspe.hhs.gov/reports/ccould-lessons-learned-report>

<sup>2</sup> [https://www.ndacan.acf.hhs.gov/datasets/pdfs\\_user\\_guides/dataset272codebook.pdf](https://www.ndacan.acf.hhs.gov/datasets/pdfs_user_guides/dataset272codebook.pdf)

differences described in this analysis are statistically significant at  $p < 0.05$  unless otherwise noted. ANOVA tests assess whether group differences for a given outcome are due to chance or likely hold in the true population. Tests of statistical significance are affected by large sample sizes, such as those present in these analyses. In our case, statistical tests should not be used to determine the substantive importance of differences. These analyses identify possible disparities in access to services funded by Medicaid, including those that can prevent child welfare engagement. They are not intended to identify causal or deterministic relationships between demographic or case characteristics and Medicaid enrollment, particularly because eligibility for Medicaid is not identifiable in our data.

## FINDINGS

Table 1. Demographic characteristics		
	N	%
<b>Total Sample</b>	<b>976,415</b>	<b>100.0%</b>
<b>Race<sup>a</sup></b>		
American Indian or Alaskan Native	2,018	0.2%
Asian	6,488	0.7%
Black or African American	292,422	29.9%
Native Hawaiian or Other Pacific Islander	1,074	0.1%
White	537,825	55.1%
Missing	136,588	13.9%
<b>Sex</b>		
Female	473,894	48.5%
Male	479,892	49.2%
Missing	22,629	2.3%
<b>Age at first report</b>		
0-1 years	154,684	15.8%
2-6 years	277,502	28.4%
7-14 years	405,439	41.5%
15-18 years	133,512	13.7%
19-21 years	179	0.1%
Missing	5,099	0.5%
<b>Maltreatment Type</b>		
Neglect	421,722	43.2%
Medical Neglect	10,481	1.1%
Physical Abuse	94,317	9.7%
Sexual Abuse	28,242	2.9%
Emotional or Psychological Abuse	11,275	1.2%
Multi-Maltreatment	82,995	8.5%
No Alleged Maltreatment <sup>b</sup>	199,048	20.4%
Missing	128,335	13.1%
<b>Disabled<sup>c</sup></b>		
No	884,938	90.6%
Yes	91,477	9.4%
<b>Child's living arrangement at time of child welfare report</b>		
Two-caregiver home	606,688	62.1%
Single caregiver home	286,873	29.4%
Out-of-home care	45,204	4.6%
Other living arrangement	35,859	3.7%
Missing	1,791	0.2%
<b>Child has foster care episode in dataset</b>		
No	893,739	91.5%
Yes	82,676	8.5%

<sup>a</sup> Race indicators were limited to single categories, and did not include information about children's ethnicities

### *Linked administrative records can provide more complete information*

Administrative data systems generally capture only data that are needed to manage a program or meet reporting requirements. Because of this, they often contain incomplete information on recipient characteristics and dynamics that may impact services. By combining information across systems, we can gather more complete information. While still not complete, in CCOULD we were able to understand much more about our sample of families served than we could with either system individually. Our Medicaid records do not uniformly or systematically collect robust demographic data. Linking to child welfare records provided more complete – albeit imperfect – documentation of children's racial identity. Additionally, systems often collect different information for the same or similar conditions, such as disability status. CCOULD's child welfare data found 2.75 percent of children were identified as disabled, compared with 7.38 percent in Medicaid data. These cases did not always overlap.

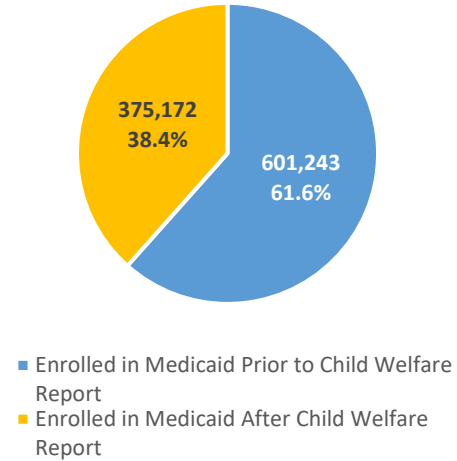
<sup>b</sup> “No alleged maltreatment” is a set category provided by child welfare services, no additional information about what is included in this category was provided.

<sup>c</sup> Disability status is based on any disability indicator in either the Medicaid or child welfare records.

**Close to 60 percent of children were enrolled in Medicaid prior to being reported to child welfare**

**Figure 1. Child Medicaid Enrollment Relative to Child Welfare Report**

We assessed the timing of Medicaid enrollment relative to the earliest report of child welfare involvement. Many children have multiple episodes of involvement in the child welfare system. Figure 1 shows the percentage of children who were enrolled in Medicaid prior to their earliest child welfare report compared to those who were enrolled after. About 62 percent of the children were enrolled in Medicaid before or at the time of their earliest child welfare record. Additionally, while we were not able to assess whether children were eligible for Medicaid prior to their child welfare report, the high Medicaid participation rates in both states sampled gives some indication that lack of eligibility is likely not a driving factor in lack of enrollment.<sup>vii</sup>



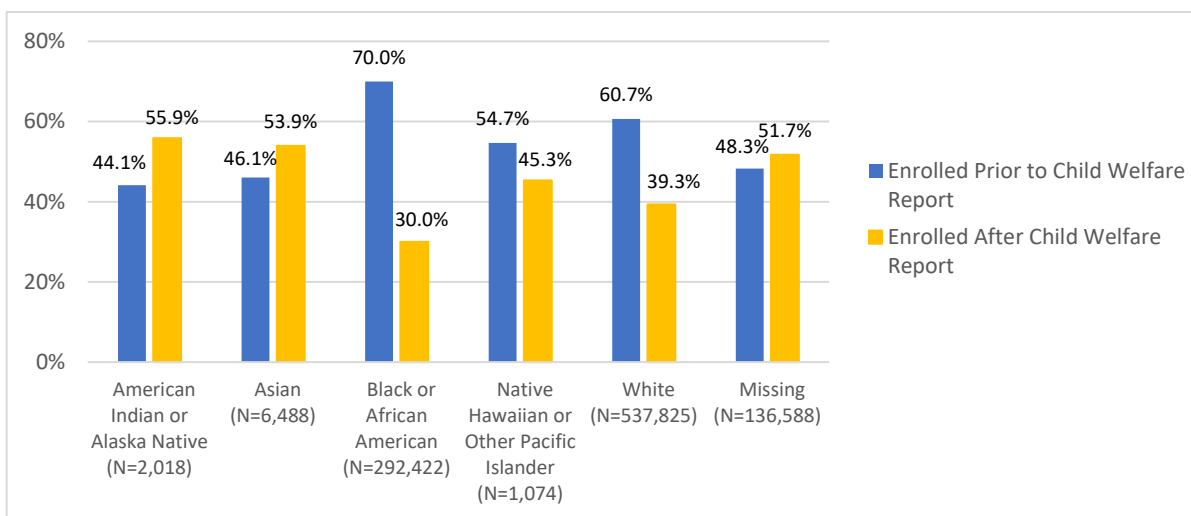
**TIMING OF MEDICAID ENROLLMENT VARIES BY CHILD CHARACTERISTICS**

Our analysis found that child enrollment in Medicaid at the time of their child welfare report differed by key demographic and case characteristics.

**Black and white children were most likely to be enrolled in Medicaid prior to child welfare reports**

When comparing Medicaid enrollment trends by children’s racial categories, the results show that for American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islander children enrollment in Medicaid more often occurred after their child welfare report. For Black and White children Medicaid enrollment was more frequently before child welfare engagement.

**Figure 2. Timing of Medicaid Enrollment Relative to Child Welfare Report by Child Race**



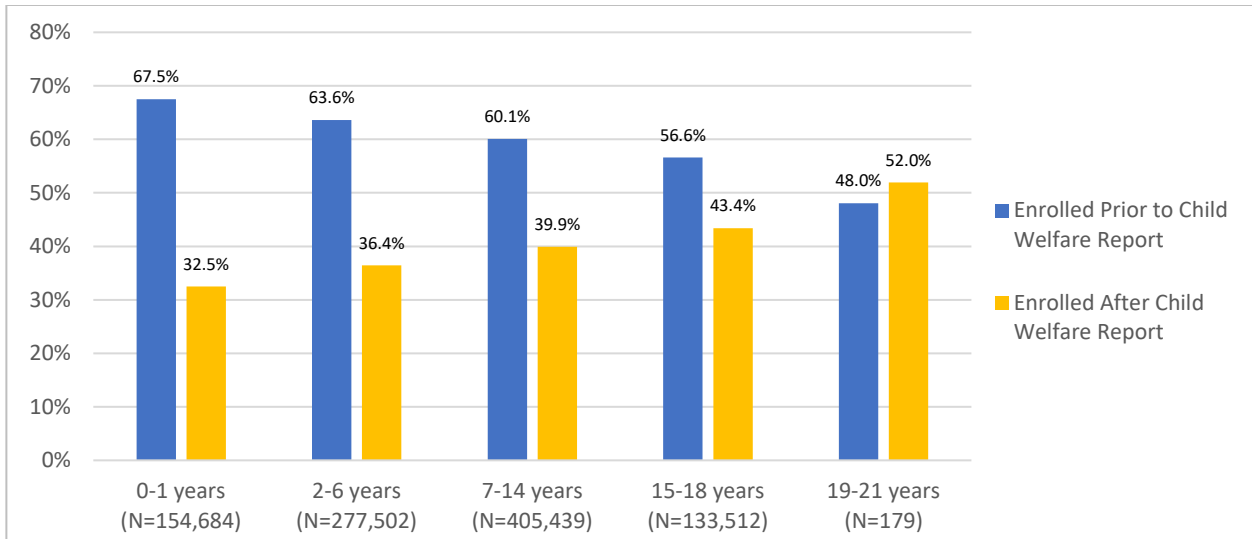
Note: Differences are statistically significant, p<0.001.

Enrollment patterns among children of different races before and after their child welfare report may be due to a number of factors. For instance, if a particular race group had lower overall enrollment compared to others, it may indicate differential Medicaid eligibility or difficulties with Medicaid access. Research found that across the United States nearly two-thirds of people who were eligible for Medicaid but not enrolled were people of color.<sup>viii</sup> Therefore, we compared overall enrollment rates for children of different race groups in Florida and Kentucky, and found no apparent relationship suggesting that population-level enrollment is driving differences in timing of enrollment for the child welfare involved population. Detailed results can be found in Appendix B.

**Older children are less often enrolled in Medicaid prior to their child welfare report**

Children in certain age groups may be driving the differences in Medicaid enrollment. Figure 3 compares enrollment timing in our sample, and demonstrates that younger children are more likely to have been enrolled in Medicaid prior to a child welfare report. For all groups of children 18 years or under, a larger proportion were enrolled in Medicaid prior to their child welfare report. Among infants, 67.5 percent were enrolled prior to a report, compared to 56.6 percent for children ages 15 to 18. Among children 18 and younger, 15-18 year-olds had the smallest percentage enrolled in Medicaid prior to a report.

**Figure 3. Timing of Medicaid Enrollment Relative to Child Welfare Report by Child Age**



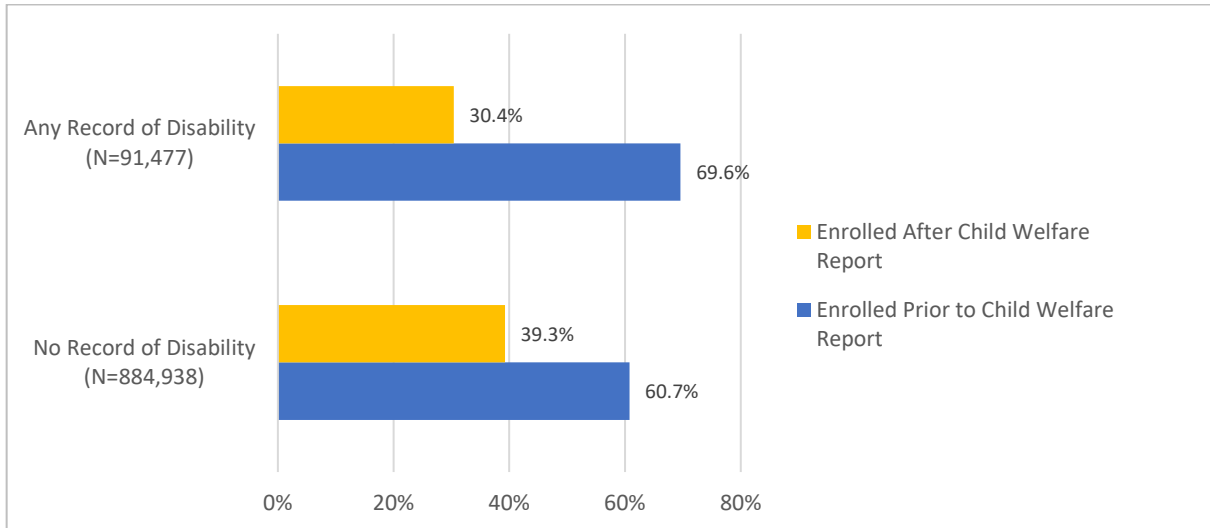
Note: Age data was missing for 5,099 children in the sample. Differences are statistically significant,  $p < 0.001$ .

**Children with disabilities had more often had Medicaid coverage prior to their child welfare report**

We also tested whether the record of the child’s disability in either the child welfare or Medicaid record was related to the timing of the child’s Medicaid enrollment, shown in Figure 4. Records of disability may affect what services children are eligible to receive in both Medicaid and child welfare, and coordination between these systems can help improve the allocation of and access to such services. Currently, this is difficult to achieve due to differences in reporting of disability in Medicaid and child welfare data. The figures for disability indicators in the respective data sources are provided in Appendix C.

Although more children with or without a disability were enrolled in Medicaid prior to their child welfare report, the difference in timing was smaller for those without a record of disability in either data source. The proportion of children with disabilities enrolled after child welfare engagement is about eight percentage points less than the overall sample. Further research is needed to understand how child disability and Medicaid access may put children at risk of child welfare involvement, and could point to a necessary area of prevention for families.

**Figure 4. Timing of Medicaid Enrollment Relative to Child Welfare Report by Child Disability**

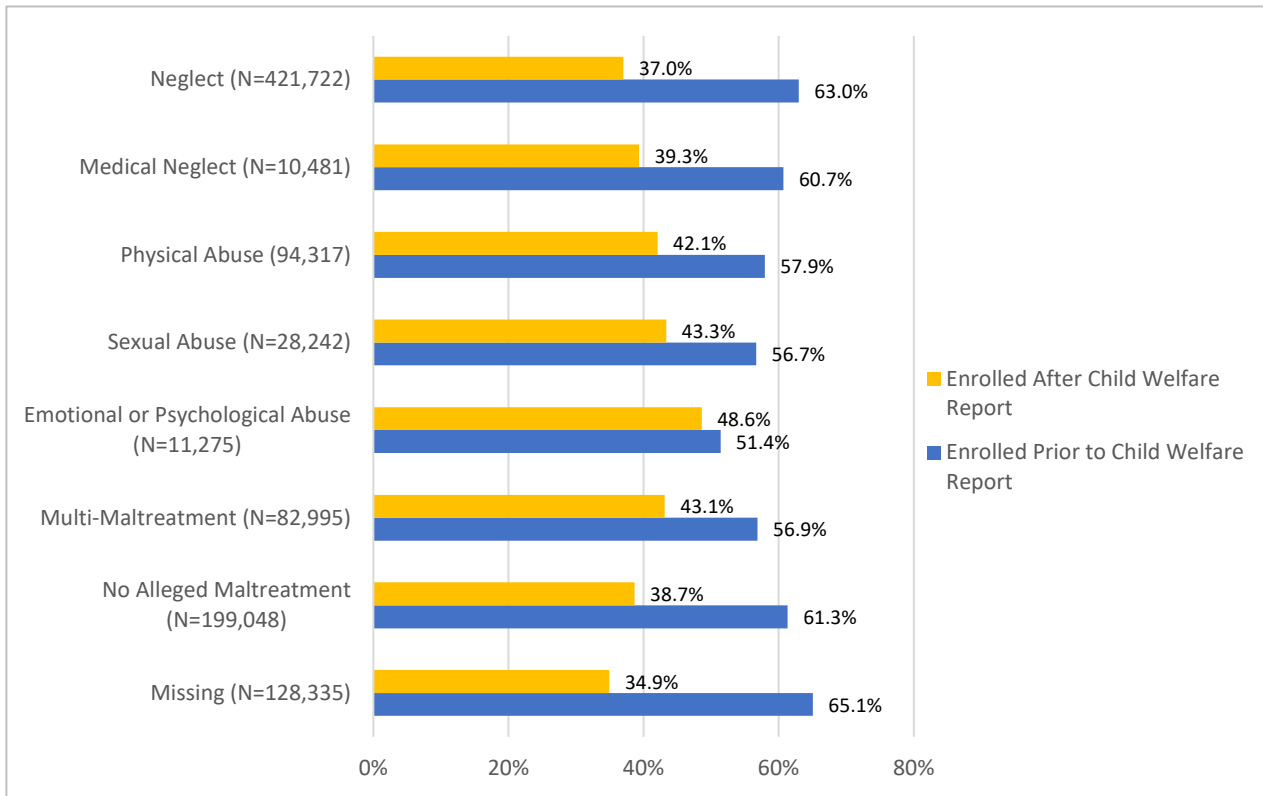


Note: Differences are statistically significant,  $p < 0.001$ .

***Children with reports related to neglect and medical neglect were more likely to have Medicaid coverage prior to report***

The factors that lead to child maltreatment differ for various types of maltreatment,<sup>x</sup> and it is a longstanding understanding that the majority of children are reported to child welfare services due to neglect.<sup>x</sup> Figure 6 shows the relationship between timing of Medicaid enrollment and maltreatment type. We found that children in all maltreatment type groups were more often were enrolled in Medicaid prior to their child welfare report, but that the proportion of children enrolled in Medicaid after their child welfare report was lower among neglect and medical neglect cases.

**Figure 6. Timing of Medicaid Enrollment Relative to Child Welfare Report by Maltreatment Type**

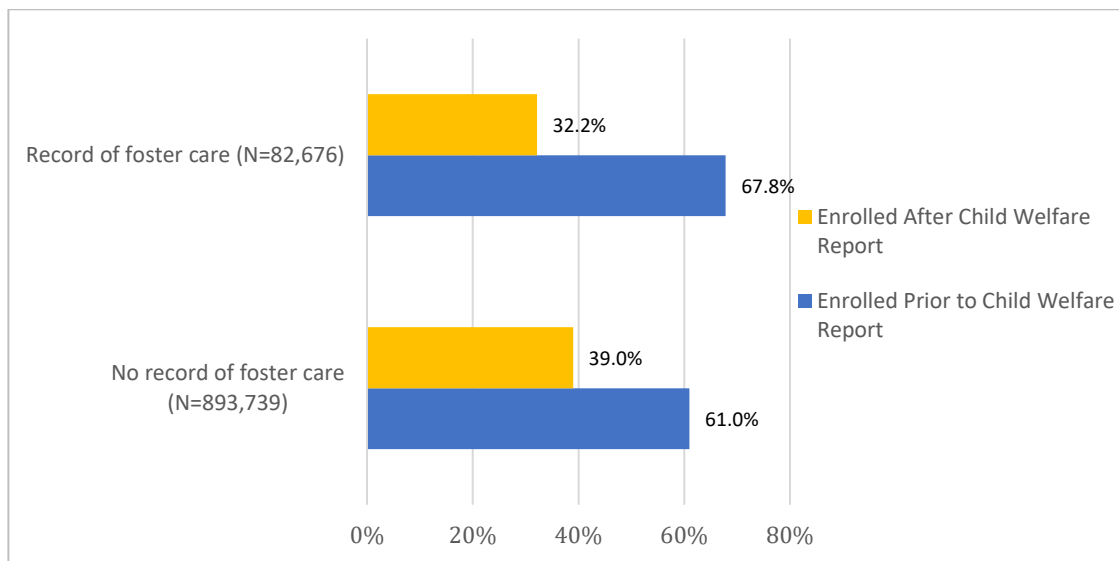


Note: Differences are statistically significant,  $p < 0.001$ .

***Timing of Medicaid enrollment was similar for children placed in foster care as those who were not***

Children who are eventually placed in foster care may be more or less likely to have been enrolled in Medicaid prior to involvement with child welfare. Children in foster care are categorically eligible for Medicaid and child welfare systems are required to assess the health needs of children in foster care. Further, there is growing concern about whether families are persuaded to engage with child welfare services and agree to out-of-home placements to access Medicaid services, particularly for those with higher health and mental health needs, for their children.<sup>xi</sup> Figure 7 shows the timing of Medicaid enrollment for children having a record of foster care placement. Although differences were statistically significant, more children in both groups were enrolled in Medicaid prior to being reported for child welfare services. These findings show that children with a foster care record more often had Medicaid coverage prior to their earliest child welfare report compared to children without a foster care record. The results do not suggest that most parents seek child welfare system involvement to obtain Medicaid. That said, over 32 percent of children in foster care did obtain Medicaid after involvement. CCOULD data cannot identify reasons for why children would not be enrolled in Medicaid before system involvement, or whether lack of enrollment was a contributing factor to out of home placement.

**Figure 7. Comparing Medicaid Enrollment Relative to Child Welfare Report by Record of Foster Care Placement**



Note: Differences are statistically significant,  $p < 0.001$ .

## CONCLUSIONS

This brief examined the timing of Medicaid enrollment for children engaged with child welfare services in two states, Florida and Kentucky. The varying differences in timing of enrollment by children’s demographic and case characteristics points to potential gaps in access to Medicaid-funded services that could reduce risk of child welfare involvement. With the enhanced role of Medicaid in child welfare prevention resulting from FFPSA, access to Medicaid services is even more relevant for this population. For those who are eligible, children who lack Medicaid coverage may be subjected to adverse physical and mental health outcomes and experience delays in receiving services. Further, Medicaid-funded services cannot play a role in primary prevention for children who only participate in Medicaid after engagement with child welfare services,

This research is a key first step in identifying one of the factors that will contribute to the success of increasing child welfare prevention services with the support of Medicaid funding. Although this research is unable to determine certain factors that are also relevant for understanding the enrollment experiences of children at risk of child welfare involvement, such as Medicaid eligibility, it highlights the need for greater coordination between Medicaid and child welfare services to improve outcomes. Further, without linked Medicaid and child welfare data, these types of analyses would be impossible and the needs of this population may be unidentified and unaddressed.

These findings may also point to specific groups of children who likely lack Medicaid coverage until after they engage with child welfare services. With regard to race and ethnicity, targeted efforts to ensure that American Indian, Alaskan Native, and Asian children have access to Medicaid may be prudent in light of larger proportions of these children enrolling only after the onset of child welfare engagement. This research also points to considerations about adequate health care for children with disabilities. In Florida and Kentucky, children with disabilities were more often covered by Medicaid prior to child welfare engagement. This suggests that lack of health care coverage is less of a driving factor in their interactions with child welfare systems than other children. Ensuring children with disabilities have adequate systems of support – which could include health care services funded by Medicaid – to prevent child welfare involvement may be an important area of prevention. Additionally, this research highlights that documentation of disability is subject to programmatic determinations that may not align between child



welfare and Medicaid services. Linked administrative data help to improve documentation of disabilities to ensure children receive services.

The finding that Medicaid enrollment prior to child welfare reports is higher in neglect and medical neglect cases presents an opportunity for further research. It may be that the relationship between poverty and neglect leads to more families facing these problems to be eligible for and enrolled in Medicaid prior to child welfare engagement. Future research using linked data sources will be able to delve into these areas of study further and in greater depth.

Though these findings are restricted to just two states, they are suggestive of areas for policy action and further research. This study focused solely on Medicaid enrollment; it did not examine need for or access to Medicaid-funded services. These results point to how child welfare system involvement may affect access to Medicaid-funded health services. Decision-makers and practitioners in child welfare and health care could find value in understanding how service utilization changes before and after child welfare system involvement. Such information could point to how system involvement may identify new health needs and facilitate connections with providers and services. The CCOULD data used in this analysis contain detailed information about service utilization by children and their caregivers, and should be used to explore the types and amount of service utilization before and after involvement in child welfare systems.

In addition, this research highlights the value of using linked data to better understand the experiences of children and families engaged with multiple public systems. Without linked data, this understanding of Medicaid enrollment timing relative to child welfare involvement would not be possible. Researchers interested in conducting research using linked child welfare and Medicaid data, such as those developed from the CCOULD project can request access to the data directly from [NDACAN](#) free of charge.

---

## REFERENCES

- <sup>i</sup> Rudowitz, R. Burns, A., Hinton, E., & Mohamed, M. (2023). *10 Things to Know About Medicaid*. Kaiser Family Foundation. Available from: <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/>
- <sup>ii</sup> Kaiser Family Foundation (2024). *Medicaid Child Participation Rates: 2016-2019*. State Health Facts. Available from: <https://www.kff.org/medicaid/state-indicator/medicaidchip-child-participation-rates/?currentTimeframe=0&selectedDistributions=child-participation-rate-2019--change-2016-2019&selectedRows=%7B%22states%22:%7B%22kentucky%22:%7B%7D,%22florida%22:%7B%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- <sup>iii</sup> Kaiser Family Foundation, 2024
- <sup>iv</sup> Searing, A., Corcoran, A., & Alker, J. (2021). *Children are Left Behind When States Fail to Expand Medicaid*. Georgetown University Health Policy Institute: Center for Children and Families. <https://ccf.georgetown.edu/2021/02/17/report-finds-medicaid-expansion-associated-with-lower-child-uninsured-rates/>
- <sup>v</sup> Child Trends (2023). "Child Welfare Financing Survey SFY2020" Available at <https://www.childtrends.org/publications/child-welfare-financing-survey-sfy2020>
- <sup>vi</sup> Mark, T. L., Dolan, M., Bradley, C., Madden, E., & Butler, V. (2022). *Linking Child Welfare and Medicaid Data: Lessons Learned from Two States*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Available at <https://aspe.hhs.gov/reports/ccould-lessons-learned-report>
- <sup>vii</sup> Kaiser Family Foundation, 2024
- <sup>viii</sup> Pillai, K., Hinton, E., Rudowitz, R., and Artiga, S. (2024). *Medicaid Efforts to Address Racial Health Disparities*. Kaiser Family Foundation. Available at <https://www.kff.org/medicaid/issue-brief/medicaid-efforts-to-address-racial-health-disparities/>
- <sup>ix</sup> Austin A.E., Lesak A.M., Shanahan M.E. (2020). Risk and protective factors for child maltreatment: A review. *Current Epidemiology Report*, 7(4):334-342. <https://doi.org/10.1007/s40471-020-00252-3>
- <sup>x</sup> U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2021). *Child Maltreatment 2019*. <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>
- <sup>xi</sup> Herman, C. (2019, January). *To Get Mental Health Help For A Child, Desperate Parents Relinquish Custody*. NPR. Available at <https://www.npr.org/sections/health-shots/2019/01/02/673765794/to-get-mental-health-help-for-a-child-desperate-parents-relinquish-custody>

## U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D  
Washington, DC 20201

For more ASPE briefs and other publications, visit:

[aspe.hhs.gov/reports](https://aspe.hhs.gov/reports)



### ABOUT THE AUTHORS

*Brett Greenfield* is a Society for Research in Child Development/AAAS Federal Policy Fellow in the Data and Technical Analysis Division in the Office of Human Services Policy in the Office of the Assistant Secretary for Planning and Evaluation.

### ACKNOWLEDGEMENTS

The RTI International project team for Child and Caregiver Outcomes Using Linked Data was led by Tami L. Mark, Melissa Dolan, Benjamin Allaire, & Christina Bradley. Emily Madden (ASPE) was the Contracting Officer's Representative, and Valeria Butler (OPRE) was the project lead.

### SUGGESTED CITATION

Greenfield, B. (2024). Timing of Medicaid Enrollment for Children Engaged with Child Welfare Services in Two States. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

### COPYRIGHT INFORMATION

All material appearing in this report is in the public domain and may be reproduced or copied without permission; citation as to source, however, is appreciated.

### DISCLOSURE

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

Links and references to information from non-governmental organizations are provided for informational purposes and are not an HHS endorsement, recommendation, or preference for the non-governmental organizations.

---

Subscribe to the ASPE mailing list to receive email updates on new publications:

<https://list.nih.gov/cgi-bin/wa.exe?SUBED1=ASPE-HEALTH-POLICY&A=1>

For general questions or general information about ASPE:

[aspe.hhs.gov/about](https://aspe.hhs.gov/about)

## APPENDIX A

### Data Preparation

Using linked administrative data requires significant data cleaning and preparation for analyses, as individual cases have to be linked across multiple datasets. Below, we provide information about how key variables were measured and operationalized from the CCOULD dataset.

Children's race indicators were derived from their child welfare records and included only single race categories for each child, and as such are unable to specifically identify which children are multi-racial. Child sex was restricted to a binary variable. Children's ages were calculated based on age at time of earliest child welfare report, but were limited to only the year of birth. Based on this calculation, some children had an age of -1, as their child welfare report could have occurred in-utero prior to birth and were therefore included with 0-1 year-olds. For the age analyses, only children up to age 21 were included in the sample, all others were coded as missing. Children were considered disabled if either the Medicaid or child welfare records indicated a disability of any kind. For child disability the Medicaid files included a binary indicator of disability, and for the child welfare record any indicator of intellectual, learning, visual, physical, or medical disability were coded as disabled. Children's living arrangements at the time of child welfare report were consolidated into four categories: single caregiver homes (mother or father), two caregiver homes (married or unmarried parents, parent + step, cohabitating partner, or other adult caregiver), out-of-home care (group or residential home, non-relative caregiver, or relative caregiver), and other/unknown living arrangement. Up to four maltreatment types were included in the dataset, and were consolidated into a single categorical variable in which children with single maltreatment types were coded by the maltreatment type, and all children with multiple maltreatment were coded as such, regardless of the combination of types. Some children were identified as having no alleged maltreatment, but information about their entry into child welfare services was not available in the dataset. Whether children had a foster care placement was determined by whether children's placement records were included in the linked CCOULD dataset. The child welfare records did not contain an indicator for any removal to out-of-home care, so this may be a conservative estimate of children with foster care placements in the sample.

The enrollment and report dates are only at the month and year, so children were considered to be enrolled in Medicaid prior to child welfare involvement if their earliest Medicaid enrollment day occurred in the month prior to their child welfare report. Children's whose Medicaid enrollment and child welfare report occurred in the same month and year were also counted as being enrolled at the time of report, as we could not determine the exact day in which the enrollment occurred.

## APPENDIX B

### Comparing Medicaid Enrollment by Race/Ethnicity in CCOULD Sample to General Child Medicaid Enrollees

Race Categories	CCOULD Sample		Child Medicaid & CHIP Enrollees	
	Enrolled in Medicaid Prior to Child Welfare Report	Enrolled in Medicaid After Child Welfare Report	Florida	Kentucky
American Indian or Alaska Native	44.10%	55.90%	<1%	N/A
Black or African American	70.00%	30.00%	28%	12%
Native Hawaiian or Other Pacific Islander	54.70%	45.30%	1.5%	1.5%
Asian	46.10%	53.90%	unavailable	unavailable
White	60.70%	39.30%	59%	78%
Missing	48.30%	51.70%	N/A	N/A
Total	61.60%	38.40%	~90%	~90%

Note: Medicaid enrollment figures are derived from the Georgetown University Health Policy Institute.<sup>xiii</sup> The race & ethnicity categories in these data differ from the CCOULD sample such as the omission of data on Asian children in inclusion of an “other/multi-racial” category. Only data that could be compared to the CCOULD sample were included.

<sup>xiii</sup> Brooks, T. & Gardner, A. (2020). “Snapshot of Children with Medicaid by Race and Ethnicity, 2018.” Georgetown University Health Policy Institute. Center for Children and Families. Available at <https://ccf.georgetown.edu/wp-content/uploads/2020/07/Snapshot-Medicaid-kids-race-ethnicity-v4.pdf>

## APPENDIX C

### Comparing Disability Indicators in Child Welfare and Medicaid Reports

	N	%
<b>Any disability indicator in Medicaid record</b>		
No	712,257	72.95%
Yes	72,084	7.38%
Missing	192,074	19.67%
<b>Any intellectual, learning, visual, physical, or medical disability indicator in child welfare record</b>		
No	949,573	97.25%
Yes	26,842	2.75%