

SOCIAL POLICY



Medi-Cal Utilization among Foster Children: Evaluating Recent California Policy Initiatives

by

Jeff Geppert

Grecia Marrufo

Dana Rapoport

Recognizing that the medical needs of foster children are often unmet, the California legislature passed three reforms during the last four years to improve the delivery of health care services to these children. First, the Health Care Program for Children in Foster Care (HCPCFC) increases the use of public health nurses to promote comprehensive preventive and specialty health services for children in foster care. Second, the Kinship Guardianship Assistance Payment program (Kin-GAP) promotes the permanency of living arrangements by providing financial aid to relatives who become the legal guardians of children in the foster care system. Lastly, Medi-Cal benefits were automatically extended to former foster children 18 to 20 years of age. In this report, we examine the effects of these reforms on the circumstances of foster children. In particular, we examine their use of Medi-Cal services to meet their physical and mental health needs. On the whole, we find that recent legislative changes have *continued inside...*

Evaluating Recent California Foster Care Policy Initiatives

This article examines the effects of three recent policy reforms on the use of Medi-Cal services by foster children.



Jeff Geppert, Grecia Marrufo, and Dana Rapoport are Research Associates at the SPHERE Institute. Marrufo and Rapoport also hold joint appointments as Research Fellows at the Stanford Institute for Economic Policy Research (SIEPR).

continued from the cover

had a positive impact on the Medi-Cal experiences of the target populations. Both HCPCFC and Kin-GAP appear to have increased the prevalence of preventive care in the form of well-being visits. Further, former foster children (18 to 20 years of age) were less likely to use emergency services after the Medi-Cal age extension than they were before the reform. These findings are useful for evaluating the current reforms and will inform future policy developments; however, because our examination addresses only the first year of the programs' implementations, our findings may underestimate the ultimate results. Long-term studies of these reforms may reveal further improvements in health care delivery for children in foster care.

Introduction

Foster children constitute a particularly vulnerable population, at risk of poor physical and mental health resulting from impoverished or unsafe living situations with their biological parents, shifting foster care placements, and difficult transitions out of foster care as young adults. Several studies have highlighted the complex and varied medical needs faced by children in foster care and have noted that many of the basic health requirements of this population are not met.¹ Such findings have captured the attention of policymakers concerned with improving the overall well-being of foster children; in California, for example, the Child Welfare Services Stakeholders Redesign Initiative was established in 2000 to examine and improve upon the system as a whole. Moreover, the state recently witnessed the implementation of three reforms intended to improve the delivery of health services to foster children. First, the State Budget Act of 1999 allocated approximately \$2.5 million—which

¹ Assessment of the Factors Influencing the Adequacy of Health Care Services to Children in Foster Care (Los Angeles, CA: UCLA Center for Healthier Children, Families, and Communities, December 2002). Available at <http://healthychild.ucla.edu/publications/ChildrenFosterCare/>.

was combined with federal funds to total almost \$10 million—to provide county public health nurses to promote access to comprehensive preventive and specialty health services for children in foster care. Second, the California legislature extended automatic no-cost Medi-Cal eligibility to former foster youth 18 through 20 years of age.² Lastly, California policymakers established the Kinship Guardianship Assistance Payment program (Kin-GAP) in 1999 to promote the permanency of living situations by providing compensation equal to current foster care payments to relatives who become formal guardians.

These innovations represent a major legislative effort and underscore California's dedication to support foster children and promote their , among other characteristics³ To date, however, little is known about the effect of these reforms on the circumstances of foster children and, in particular, whether these reforms have changed these children's use of Medi-Cal services. Such information is crucial for evaluations of the current reforms and

for future policy development. This brief is based on a study funded by the California HealthCare Foundation that uses the Medi-Cal Eligibility Data System (MEDS) and Medi-Cal paid claims data files provided by the California Department of Health Services to provide a rich depiction of medical services utilization among foster children and to fill many of the gaps in our knowledge about improvements in health care services for this population.

Foster Care and Medi-Cal

The foster care system is faced with an array of challenges, including the question of how to balance a child's safety with his or her right to remain in the custody of his or her family. The system must also interact with other state services, such as health care and education, to ensure that the full range of each child's needs is met; moreover, many foster care services cannot be delivered without approval from the judicial system.

One feature of California's foster care system is its automatic linkage to Medi-Cal, California's public

health insurance program for persons with limited resources or disability. Current foster children and those who have recently exited the system due to age or via the Kin-GAP program are automatically eligible for Medi-Cal, which provides a number of basic benefits, including physician services, inpatient and outpatient hospital services, prenatal care, family planning assistance, vaccines, rural health clinic services, laboratory and x-ray services, and EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services. All beneficiaries are also eligible for medically necessary mental health services. Moreover, unlike most individuals participating in Medi-Cal who are required to enroll in a Medi-Cal managed care plan if offered by their county, foster children are generally allowed to choose between traditional fee-for-service Medi-Cal coverage and enrollment in a Medi-Cal managed care plan. Fewer than 10 percent of those foster children with the option of both service delivery methods choose to enroll in a managed care plan.

² This act was passed in response to the federal Chaffee Foster Care Independence Act of 1999.

³ Private programs have also influenced the foster care system in recent years. For example, the Annie E. Casey Foundation's Family-to-Family Initiative is a national program that gives local and state governments the opportunity to re-conceptualize and redesign their foster care systems. More information on the program is available at <http://www.aecf.org/initiatives/familytofamily/overview.htm>.

Characteristics of Foster Children and Their Use of Medi-Cal

The circumstances that cause children to enter the foster care system, as well as the trauma of being separated from their biological parents and the uncertainty

of many placements, distinguish foster children from other groups of children. At the same time, the variation within the foster care population is large, with foster children differing by age, ethnicity, and region of residence, among other characteristics.⁴ The diversity

in the attributes of foster children makes their Medi-Cal utilization complex and multifaceted.

Demographic Characteristics.

Table 1 provides an overview of the foster care population in California in 2001, dividing the children into three categories: (1) current foster children, (2) former foster children (18- to 20-year-olds who have aged out of the foster care system), and (3) Kin-GAP children (individuals who exited foster care due to the initiation of formal kinship care).⁵ With respect to ethnicity, Table 1 shows that Kin-GAP children were approximately 1.5 to 2 times more likely to be non-white than former and current foster children. In comparison to current foster children, Kin-GAP children were much less likely to be younger than 3 years old (2 percent versus 10 percent) and more likely to be between 6 and 11 years old (46 percent versus 32 percent). Whereas former foster children were equally divided across the sexes, current foster children were slightly more likely to be male, in contrast to Kin-GAP children, who were slightly

	Current Children (%)	FosterFormer Children (%)	Kin-GAP Children (%)
Ethnicity			
Black	19	16	20
Hispanic	18	12	37
White	60	70	40
Native American	1	0	2
Other	2	2	1
Gender			
Female	48	50	51
Male	52	50	49
Age			
0 to 2	10	0	2
3 to 5	12	0	14
6 to 11	32	0	46
12 to 17	41	0	36
18+	6	100	2
Region			
Bay Area	13	4	10
North and Mountain	5	3	9
Farm Belt	18	7	37
Southern California	64	85	44
Number of Children	68,150	2,396	1,273

Source: Medi-Cal Eligibility Data System (MEDS) and Medi-Cal paid claims. Sample consists of children in foster care for at least three quarters of the year who received medical services through fee-for-service Medi-Cal.

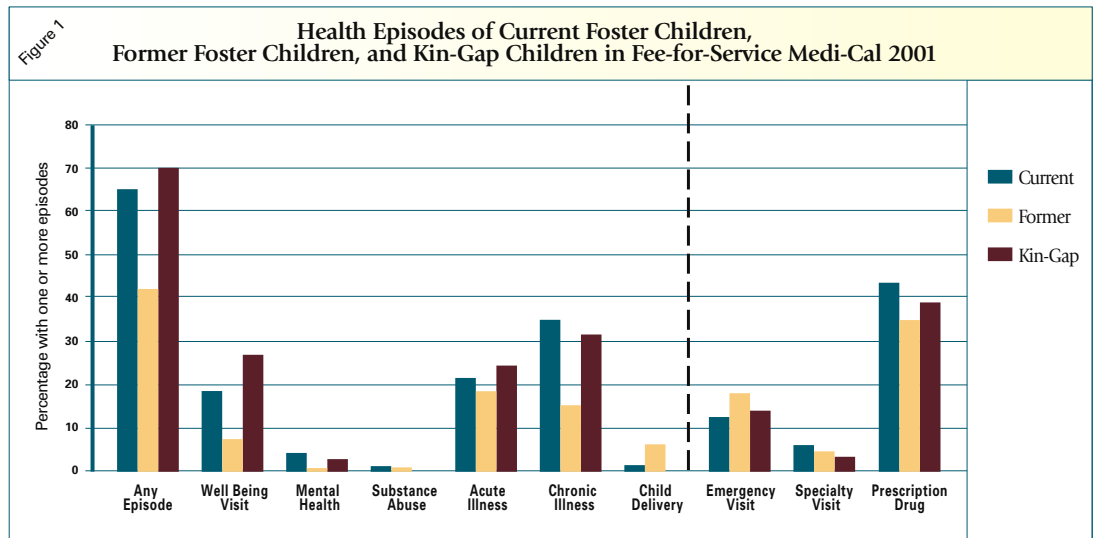
⁴ For the purposes of this analysis, we divide California into four regions: 1) Bay Area comprises Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma; 2) Southern California consists of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura; 3) Farm Belt contains Colusa, El Dorado, Fresno, Glenn, Imperial, Kern, Kings, Madera, Merced, Monterey, Placer, Sacramento, San Benito, San Joaquin, San Luis Obispo, Stanislaus, Sutter, Tulare, Yolo, and Yuba; and 4) North and Mountain includes Alpine, Amador, Butte, Calaveras, Del Norte, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

⁵ To remain consistent with the analysis described below, we focus on those children who were in the foster care system for at least three quarters of the year and received Medi-Cal services through the fee-for-service delivery method.

more likely to be female. Lastly, 85 percent of the former foster children lived in Southern California, in comparison to 64 percent of the current foster children and 44 percent of the Kin-GAP children. Kin-GAP children were much more likely than current and former foster children to

live in the Farm Belt and the North and Mountain region.

Medi-Cal Utilization. An analysis of the Medi-Cal claims of approximately 90 percent of California’s foster care population reveals substantial variation in utilization across demographic attributes and regions.⁶ To better understand the services received by these children, we classify medical events into six mutually exclusive types of health episodes: well-being visits, mental health episodes, substance abuse episodes, acute illnesses, chronic illnesses, and child delivery. A well-being visit is defined as an episode lasting less than 30 days and incurring less than \$50 in Medi-Cal



expenditures. An acute illness, on the other hand, is defined as an episode lasting less than 30 days and incurring more than \$50 in Medi-Cal expenditures. Chronic illness episodes are those events lasting more than 30 days. Episodes in which at least 20 percent of the Medi-Cal expenditure is accounted for by mental health or substance abuse diagnoses are defined as mental health and substance abuse episodes, respectively. Lastly, child delivery is any episode associated with live-born or normal delivery diagnosis codes. In addition to these categories, we analyze three types of utilization that can occur during any type of health episode:

emergency department visits, specialty visits, and prescription drug receipt.

Figure 1 summarizes the prevalence of health episodes among children in the foster care system who were enrolled in fee-for-service Medi-Cal for at least three quarters during 2001, specifically showing the percentage of children with at least one of each type of episode during the year. Comparing children in different types of foster care, **Figure 1** shows that 70 percent of Kin-GAP children had at least one health episode of any nature, in comparison to only 42 percent of former and 65 percent of current foster children. Former

⁶ The remaining 10 percent of the foster care population received care through a Medi-Cal managed care plan, for which no service-specific claims were generated. Consequently, our results are restricted to children receiving fee-for-service coverage. Foster children receiving fee-for-service coverage were more likely to be white (60 percent vs. 44 percent) and to live in Southern California (64 percent vs. 58 percent) than those who were enrolled in a managed care plan during at least one quarter.

foster children were the least likely to have every type of episode, except for child deliveries and emergency visits. **Figure 2** looks at the three categories of foster children as a whole and shows that Medi-Cal utilization decreased with age, as did chronic illness episodes, specialty visits, and prescription drug receipt. The prevalence of well-being visits and acute illnesses decreased with age for children older than two years.

Across regions in California, Medi-Cal utilization was fairly constant, with the biggest difference occurring in well-being visits, which were much less common among foster children in the North and Mountain region than in any other area. At

the same time, foster children in the North and Mountain region were more likely than children in other parts of the state to have mental health episodes and emergency visits.

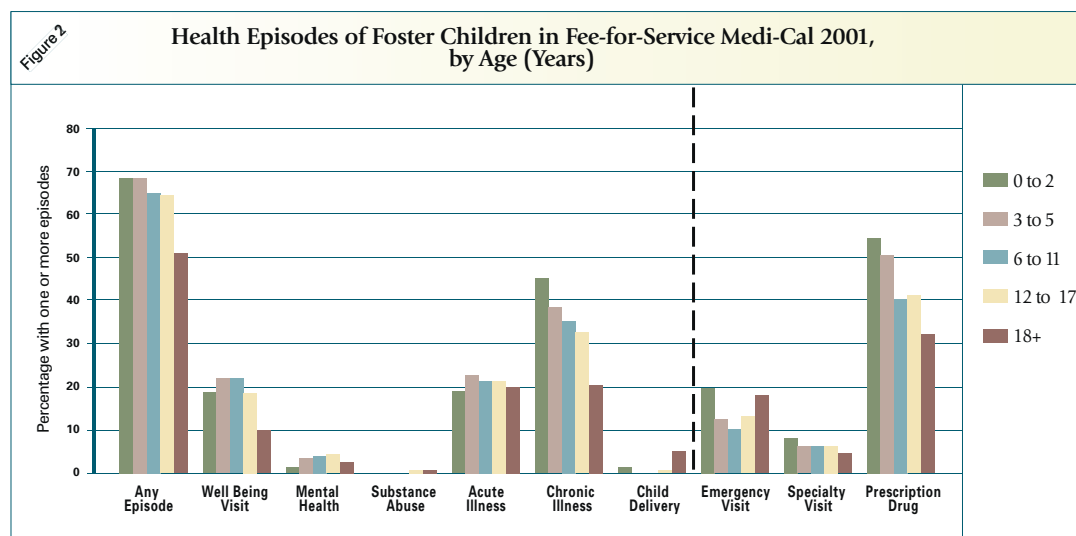
The Effects of Recent Policy Changes

To assess the effects of the three recent California policy changes on the likelihood of foster children experiencing different types of health episodes, we exploit probability models, controlling for the influence of other variables simultaneously related to health service utilization.⁷

Health Care Program for Children in Foster Care. The Health Care

Program for Children in Foster Care (HCPCFC) provides funding for public health nurses to promote health services for children in California’s foster care system. Under the HCPCFC, nurses work closely with children’s caseworkers or probation officers to ensure that their health care needs are met. Nurses provide assistance in the interpretation of health care information and the development of health care resources, in addition to participating in training programs for health care workers, child welfare workers, probation officers, and juvenile court staff.⁸ Since the program’s inception in the beginning of 2000, federal and

local expenditures devoted to this program have varied substantially across counties, as has the ratio of foster children to public health nurse. Although the average number of foster children per public health nurse was 345 in 2002, this ratio ranged from as high as 600 children per nurse (in Del Norte and



⁷ More detailed information on the analytical methods employed is available from the authors upon request.

⁸ State of California, Health and Human Services Agency, Department of Social Services All County Information Notice No. I-55-99.

Kings Counties) to approximately 100 or fewer children per nurse (in Modoc and Mono Counties). Similarly, the amount of Federal Title XIX matching funds (grants to states claimed for the HCPCFC) was less than \$25 per foster child in Del Norte and Calaveras Counties, but exceeded \$250 per foster child in Plumas, Amador, Trinity, Mono, and Mariposa Counties.⁹

Exploiting this variation in

program intensity, we use a multivariate regression framework to isolate the impact of the HCPCFC on the likelihood of foster children experiencing health episodes. To allow for the sporadic nature of medical events, we analyze Medi-Cal utilization among children enrolled in foster care for at least three quarters of the year, comparing the likelihood of health episodes in regions with varying

numbers of foster children per public health nurse. In particular, **Table 2** compares changes in the probability of a health episode from 1999 to 2001 for foster children living in counties with particularly low concentrations of public health nurses—more than 500 foster children per nurse—to the analogous changes in the probabilities of health episodes for children living in counties with 330-500 foster children per nurse (column 3) and counties with less than 330 foster children per nurse (column 4).¹⁰

Assuming our statistical approach adequately controls for systematic differences among counties, the reported numbers reflect the expected outcome: Medi-Cal utilization increased when more public health nurses were provided. For example, the first row of the table suggests that foster children in counties with fewer than 330 or 330-500 foster children per nurse were 2 percent more likely to have a health episode of any type than the corresponding child living in a county with more foster children per public health nurse.

Health Episode	Sample	330-500 Foster Children per PHN vs. > 500 Foster Children per PHN	< 330 Foster Children per PHN vs. > 500 Foster Children per PHN
Any Health Episode	All	0.02**	0.02**
Emergency Visit	Chronic	0.03**	0.03**
Emergency Visit	Non-Chronic	0.00	0.00**
1 Mental Health Episode	All	0.00	0.00**
Well-Being Visit	Non-Chronic	0.01**	0.01**
Specialty Visit	Chronic	0.02*	0.02**
Chronic	All	0.01	0.00**

Source: Medi-Cal Eligibility Data System (MEDS) and Medi-Cal paid claims. Notes: Reported numbers are mean differences in the probability of a health episode from 1999 to 2001 for foster children living in counties with more than 500 foster children per nurse to the analogous changes in the probabilities of health episodes for children living in counties with 330-500 foster children per nurse and counties with less than 330 foster children per nurse. All regressions control for individual characteristics (ethnicity, age, county, and number of quarters previously enrolled in foster care or CalWORKS) and county characteristics (regional fixed effects, county prevalence rates, and county share of foster children in group homes). A '*' indicates that the mean difference is statistically significant at the 90% confidence level, and a '**' indicates the effect is significant at the 95% level.

⁹ These figures were calculated with information from the California Department of Health Services and the Child Welfare Research Center, U.C. Berkeley, School of Social Welfare, Child Welfare Services Case Management System (CWS/CMS) Reports.

¹⁰ Our model also controls for individual characteristics (age, ethnicity, county of residence, and number of quarters enrolled in foster care or CalWORKS during the previous year) and county attributes (foster care prevalence rates, share of foster children in group homes, and regional fixed effects).

Looking more carefully at different types of health episodes, we find that children with chronic illnesses who lived in areas with more public health nurses per foster child were 3 percent more likely to have an emergency department visit. Children with non-chronic illnesses in areas with a higher nurse-to-child ratio were 1 percent more likely to have a well-being visit than children in areas with a lower concentration of public health nurses.

Case management by the HCPCFC's public health nurses may explain some of the increased Medi-Cal utilization among foster children. For example, these nurses may have encouraged children to receive preventive care in the form of well-being visits, and, in the case of foster children with chronic illness episodes, to seek care when necessary through visits to the emergency department. Despite the small magnitude of the results, our estimates suggest that there were quantifiable effects of the Health Care Program for Children in Foster Care on the Medi-Cal utilization among foster children. Moreover,

our results may underestimate the impact of the program. Because our estimates rely on variation across counties in average outcomes, the relatively small HCPCFC program may appear to have minimal effects, even if foster children derive substantial benefits from interacting with public health nurses. If a small share of foster children in areas with high concentrations of public health nurses obtained large benefits from the program, such results would be masked in the county-level average effects that we estimate. Thus, we interpret our results cautiously in the absence of data on the allocation of HCPCFC resources to individual children.

Kinship Guardianship Assistance Payment Program. Before implementation of the Kinship Guardianship Assistance Payment (Kin-GAP) Program on January 1, 2000, guardians who were related to the children they cared for received CalWORKs benefits, which were in general smaller than the foster care payments to non-relatives. With the goal of promoting permanency in the living arrangements

of foster children, the Kin-GAP program changed this policy by increasing the payment to relatives who assume formal guardianship to equal the basic foster care reimbursement. In addition to increasing the rates of children living in permanent situations, the Kin-GAP program, which preserves Medi-Cal eligibility for participating children, could influence Medi-Cal utilization among these children. Indeed, Figure 1 shows Kin-GAP children were more likely than former and current foster children to experience any type of health episode, suggesting that the delivery of Medi-Cal services may be related to the permanency of a child's placement with a relative caregiver.

To gain a better understanding of the differences in Medi-Cal utilization among Kin-GAP children and current foster children, we apply a multivariate model to isolate differences in health outcomes explained by Kin-GAP enrollment from other factors that might also affect Medi-Cal usage. Table 3 summarizes the results of this exercise, with each row representing a distinct health

outcome of interest, as indicated in the first column. The third column presents the impact of Kin-GAP enrollment by showing the difference between the probabilities that a foster child and a Kin-GAP child experienced a health episode during three quarters of 2001. For example, the first row shows that foster children were 5 percent less likely than their Kin-GAP counterparts to experience a health episode. Considering types of Medi-Cal usage in more detail, the table shows that foster children were less likely than Kin-GAP children to have well-being

visits and trips to the emergency department; however, they were more likely to have a mental health episode. More specifically, a foster child with a non-chronic episode was 7 percent less likely to have a well-being visit than the analogous Kin-GAP child. Foster children with chronic and non-chronic episodes were 2 percent less likely to experience a trip to the emergency department than their Kin-GAP counterparts. Finally, foster children were 1 percent more likely to have a mental health episode than Kin-GAP children.

In addition to having higher rates of overall Medi-Cal utilization than foster children, Kin-GAP children were more likely to receive preventive medical care in the form of well-being visits. This finding suggests that guardians who are also relatives may play a larger role than unrelated foster parents in securing a regular source of medical care for the children who live with them. Kin-GAP children were also less likely to experience a mental health episode than foster children, a result that may follow from the emotional stability of placements with relatives. Although we find quantifiable differences in the Medi-Cal usage of Kin-GAP participants, few children were eligible to participate in the program during the time period of our analysis, and our results therefore reflect the effects of the program on a small group of children.

Extended Medi-Cal Eligibility for Former Foster Children 18- to 20-Years-Old. Beginning on October 1, 2000, California extended automatic Medi-Cal eligibility to all children who were in foster care on their

Table 3 Comparing the Probabilities of Health Episodes for Foster Children and Kin-GAP Children, 2001

Health Episode	Sample	Foster Children vs. Kin-GAP Children
Any Health Episode	All	-0.05**
Emergency Visit	Chronic	-0.02**
Emergency Visit	Non-Chronic	-0.02**
1 Mental Health Episode	All	0.01**
Well-Being Visit	Non-Chronic	-0.07**
Specialty Visit	Chronic	0.01

Source: Medi-Cal Eligibility Data System (MEDS) and Medi-Cal paid claims.
 Notes: Reported numbers are mean differences in probabilities for the two groups. All regressions control for ethnicity, age, county, and number of quarters previously enrolled in foster care or CalWORKS. A “*” indicates that the mean difference is statistically significant at the 90% confidence level, and a “***” indicates the effect is significant at the 95% level.

18th birthday until they reach the age of 21, regardless of their income or assets. Although some children aging out of foster care maintained Medi-Cal eligibility prior to the reform, they had to reapply for the health coverage, and advocates claimed that many children failed to receive coverage due to confusion about the reapplication process. An examination of Medi-Cal enrollment rates for this population reveals that approximately two-thirds of the former foster children who were Medi-Cal beneficiaries in

2001 were “new” enrollees—those who would not have been enrolled in the absence of the new policy—while the remaining one-third would have maintained eligibility through another category regardless of the expansion.

Table 4 presents results from a multivariate analysis of the effects of the new Medi-Cal eligibility category on the delivery of health services to newly emancipated foster children. The third and fourth columns of the table show the difference between the

probabilities of a former foster child and a 17-year-old current foster child experiencing a health episode during 1999 and 2001, respectively. The difference between these probability differentials can be interpreted as the effect of the Medi-Cal extension on the probability of a health episode. In the first row, the table shows that former foster children in 1999 were 13 percent less likely than current foster children to have a health episode of any type.¹¹ Two years later, after the reform, the difference between the probabilities of former and current foster children having a health episode was slightly greater at 14 percent, indicating that the eligibility extension decreased the overall likelihood of having any health episode by one percentage point. Although the magnitude of the result is small, we find a larger effect of the reform on the use of emergency rooms. In particular, whereas former foster children with a chronic illness in 1999 were 4 percent more likely to visit the emergency room than the analo-

Health Episode	Sample	1999 Probability Differential: Former Foster Children vs 17-year-old Current Foster Children	2001 Probability Differential: Former Foster Children vs 17-year-old Current Foster Children
Any Health Episode	All	-0.13**	-0.14 ^{††}
Emergency Visit	Chronic	0.04**	-0.06 ^{††}
Emergency Visit	Non-Chronic	0.06**	-0.04 [†]
1 Mental Health Episode	All	-0.02	-0.04 ^{††}
Well-Being Visit	Non-Chronic	-0.01	-0.01
Specialty Visit	Chronic	-0.01	0.00.

Source: Medi-Cal Eligibility Data System (MEDS) and Medi-Cal paid claims. Notes: Reported numbers are mean differences in probabilities for the two groups. All regressions control for ethnicity, age, county, and number of quarters previously enrolled in foster care or CalWORKS. A “***” indicates that the mean difference is statistically significant at the 95% confidence level, a “††” (“†”) indicates the difference between the 2001 and 1999 differentials is significant at the 95% (90%) level

¹¹ The 1999 sample of former foster children consists of those children who aged out of foster care and were enrolled in Medi-Cal prior to the automatic extension of the health insurance program to this group. To the extent that this sample consists of individuals most likely to seek medical care, our 1999 estimates are a lower bound of the difference in the probabilities of medical episodes for former foster children and current 17-year-old foster children.

gous 17-year-old foster child, former foster children in 2001 were 6 percent less likely to visit the emergency room than a current foster child. A similar result is true for foster children with non-chronic episodes, suggesting that the reform decreased the likelihood of a former foster child visiting the emergency room by 10 percentage points. Further, former foster children in 2001 were 4 percent less likely than their current foster children counterparts to have a mental health episode, whereas the likelihoods of mental health episodes among these two groups in 1999 were statistically indistinguishable.

These findings imply that the extension of Medi-Cal to former foster children decreased the use of medical services among this group,

primarily in the form of emergency department visits and mental health episodes. To the extent that emergency care is used by individuals without a regular source of care, we find that former foster children enrolled in Medi-Cal were less likely to use such services after the extension. However, we do not find an accompanying increase in other forms of medical utilization, which might have signaled that care was shifted between different types of medical delivery.

Conclusion

On the whole, we find that recent legislative changes in the foster care system have had a positive impact on the Medi-Cal experiences of the target populations. Both the Health Care Program for Children in Foster Care and Kin-GAP appear

to have increased the prevalence of well-being visits. Moreover, former foster children were less likely to use emergency department services after the Medi-Cal age extension than they were before the reform. Despite the statistical significance of the effects noted above, the magnitude of our results is generally small and there are several measures of medical utilization for which we find no measurable effects. However, because our analysis examined only the first-year effects of these reforms, our findings are likely to underestimate the ultimate results and should be accompanied by future research to assess how these changes affect Medi-Cal utilization among foster children over a longer horizon.

Related Publications (available at www.sphereinstitute.org)

Utilization of Medi-Cal Services by Current and Former Foster Care Children, Jeff Geppert, Grecia Marrufo, and Dana Rapoport, report to the California HealthCare Foundation, September 2003.

This report draws on research funded by the California HealthCare Foundation. We also thank the California Department of Health Services for providing data to assist in this research. The authors would like to thank Cathy Senderling for her insightful and detailed comments.



SPHERE Institute

1415 Rollins Road, Suite 204

Burlingame, CA 94010

Phone: (650) 558-3980

Fax: (650) 558-3981

www.sphereinstitute.org



NONPROFIT ORG
U.S. POSTAGE PAID
SAN FRANCISCO, CA
PERMIT #224

California Policy Review

IN THIS ISSUE



Medi-Cal Utilization among Foster Children: Evaluating Recent California Policy Initiatives

To subscribe to the California Policy Review please send an e-mail message to info@sphereinstitute.org with your name and mailing address, or call the SPHERE Institute phone number listed above (ext. 24).

California Policy Review

The California Policy Review is published by the SPHERE Institute and the Stanford Institute for Economic Policy Research, with generous support from the Public Policy Institute of California.



Executive Editor: Thomas MaCurdy

Series Editor/Economic Policy: Michael Dardia

Series Editor/Social Policy: Dana Rapoport

Production Editor: Gregory Rosston

The California Policy Review examines topics relevant for the public policy community in California, including state and local government. Each issue addresses a single topic by exploring an emerging policy topic, distilling key research findings, or considering the tradeoffs among policy options.

The California Policy Review is divided into two occasional series: Growth and Employment and Social Policy. Authors for both series are drawn from universities, think tanks, and government agencies.