California Children's Trust

Public Comment from Rhea Boyd, MD, MPH on 1915(b) waiver

I am a pediatrician, public health advocate, and scholar who writes and teaches about the impacts of structural racism and inequity on health. I have serious concerns with the 1915(b) waiver, which as currently proposed by DHCS, erodes critical advancements in addressing the ways racism and inequity shape children and adolescents' behavioral health outcomes.

First, requiring a threshold ACEs score to be eligible for services makes ACEs screening coercive rather than the choice of families and caregivers. It removes the right to informed refusal, which is critical for patient autonomy. This approach also entrenches a single measure of adversity, one that ignores the sociopolitical roots of adversity, as the primary gatekeeper for services that should be available to children without having to endure such invasive questions or center their care around their deficits/most traumatic moments.

Scholars, including the original author of the ACEs study Dr. Robert Anda, have cautioned against the use of the ACEs score in this way, because as they noted: "Despite its usefulness in research and surveillance studies, the Adverse Childhood Experience (ACE) score is a relatively crude measure of cumulative childhood stress exposure that can vary widely from person to person. Unlike recognized public health screening measures, such as blood pressure or lipid levels that use measurement reference standards and cut points or thresholds for clinical decision making, the ACE score is not a standardized measure of childhood exposure to the biology of stress. The authors are concerned that ACE scores are being misappropriated as a screening or diagnostic tool to infer individual client risk and misapplied in treatment algorithms that inappropriately assign population-based risk for health outcomes from epidemiologic studies to individuals. Such assumptions ignore the limitations of the ACE score." (reference: Anda RF, Porter LE, Brown DW. Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications. Am J Prev Med. 2020 Aug;59(2):293-295. doi: 10.1016/j.amepre.2020.01.009.)

Second, scholars have also raised concerns about the ways current ACEs screens are being used to inappropriately over-refer families of color into the child protection services and child welfare system. By scrutinizing the experiences of caregivers and children, and over-sampling families on Medicaid (who are the primary utilizers of the screener), this results in a system that compounds the historically racist depictions of parents of color and families who live in poverty, as unfit, and risks exacerbating forms of family separation that already exist. Requiring threshold scores for services will only further this problem.

Third, requiring ACEs screeners for accessing services exhausts precious resources that could be used to address forms of structural inequality and racism that underpin childhood adversity. This compounds the ways many children are already denied access to vital behavioral health services.

I beseech those in power to NOT require threshold ACEs scores, which is another manifestation of medical necessity, for accessing behavioral health services for children and adolescents. The risks of this approach are widely known, which makes the harms this approach could cause, completely preventative. At a time when the nation's consciousness about the harms of racism is growing, it would be shameful to see an approach like this advance in a state as progressive as California, given the predictable toll it will take on families and children of color.

Respectfully submitted,
Rhea Boyd, MD, MPH