Date of Hearing: July 6, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 428 (Hurtado) – As Introduced February 12, 2021

SENATE VOTE: 39-0

SUBJECT: Health care coverage: adverse childhood experiences screenings.

SUMMARY: Requires a health care service plan (health plan) contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage for adverse childhood experiences (ACEs) screenings. Defines ACEs as an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. Specifically, **this bill**:

EXISTING LAW:

1) Requires, under federal law, large group carriers that cover mental health or substance use disorders to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as visit limits) applicable to mental health benefits are no more restrictive than those applied to medical or surgical benefits (commonly referred to as the federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008).

2) Establishes the Department of Managed Health Care (DMHC) to regulate health plans; the California Department of Insurance (CDI) to regulate health insurers; and, the California Health Benefit Exchange (the Exchange or Covered California) to compare and make available through selective contracting health insurance for individual and small business purchasers as authorized under the federal Patient Protection and Affordable Care Act.

3) Requires issuers of individual and small group coverage to, at a minimum, cover essential health benefits (EHBs) in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

4) Requires health plans and disability insurers to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions; establishes new requirements for medically necessary care determinations and utilization review; and bans discretionary clauses in health plan contracts.

5) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care benefits.

6) Establishes a schedule of benefits under the Medi-Cal program, which includes Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for any individual under 21 years of age, consistent with federal Medicaid requirements. Defines, through regulation,

"screening services" for purposes of EPSDT to mean:

a) An initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program;

b) A health assessment, examination, or evaluation of a Medi-Cal eligible individual under 21 years of age by a licensed health care professional acting within his or her scope of practice, at intervals other than the CHDP intervals, to determine the existence of physical or mental illnesses or conditions; or,

c) Any other encounter with a licensed health care professional that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition for a Medi-Cal eligible person under 21 years of age.

7) Requires that screening services provided under the EPSDT Program include screening for trauma, defines trauma for the purpose of screening, and requires DHCS, in consultation with the Department of Social Services (DSS), behavioral health experts, child welfare experts, and stakeholders, to adopt, employ and develop tools and protocols for the screening of children for trauma.

8) Requires mental health plans to provide specialty mental health services to eligible Medi-Cal beneficiaries, including both adults and children. Includes EPSDT within the scope of specialty mental health services for eligible Medi-Cal beneficiaries under the age of 21 pursuant to federal Medicaid law.

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC estimates the total cost of this bill to be approximately $21,000 Managed Care Fund (MCF) and 0.1 personnel year (PY) in fiscal year (FY) 2021-22, and $108,000 MCF and 0.6 PY in FY 2022-23. CDI would need $9,000 FY 2021-22; $20,000 in FY 2022-23; $9,000 FY 2023-24 and $9,000 in ongoing costs to review health insurance policy forms for compliance with the new benefit. According to the California Health Benefits Review Program (CHBRP),

1) Estimated, in 2022, 21.9 million Californians enrolled in state regulated health insurance, all of them would have insurance for these screenings;

2) Estimates this bill would increase total net annual expenditures by $36,060,000 or .03% for enrollees and insureds covered by state regulated plans and policies. This is all due to an increase in total health insurance premiums paid by employers and enrollees for the newly covered benefit. There would be no impact in enrollee expenses for covered and/or noncovered benefits given no cost-sharing for ACEs screening;

3) Projects an estimated $1,983,000 impact, or 0.03%, for the California Public Employees' Retirement System (CalPERS) HMO employer expenditures from the General Fund and special funds; and,

4) Finds no impact to Medi-Cal because of the availability of reimbursement through 2022.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, recent research has highlighted the link between ACEs and a decline in an individual's long-term health outcomes. A groundbreaking *American Journal of Preventive Medicine* study demonstrated that a child's exposure to traumatic events substantially impacts his or her long-term health. The findings indicate that identifying a child's exposure to abuse, neglect, discrimination, violence and other adverse experiences, and connecting children and families to early intervention services that can help families heal from trauma or slow or reverse the expected negative health outcomes, is a core component of healthcare. This bill allows providers to screen patients for ACEs and provide necessary services early. It requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage for adverse childhood experiences screenings. The author concludes that many experts have warned that the current COVID-19 pandemic is a traumatic stressor, so expanding ACEs coverage now will enable doctors to mitigate what would otherwise become a compounding trauma in the future.

2) **BACKGROUND**.

   a) **Medi-Cal coverage.** In 2017, California passed Assembly Bill 340 (Arambula), Chapter 700, Statutes of 2017, and with its enactment, made available screening for childhood trauma to the other EPSDT screenings covered by Medi-Cal for those under 21 years of age. AB 340 contemplated trauma screening at least once every five years for children and required DHCS to convene a work group to review tools and protocols for screening children for trauma as defined within EPSDT, a Medi-Cal benefit for individuals under age 21 years. The AB 340 Workgroup recommended to DHCS that Medi-Cal providers be given the following three options for screening pediatric populations (children and youth under the age of 21) for exposure to trauma:
      i) Utilize the Bay Area Research Consortium on Toxic Stress and Health screening tool, called PEARLS, alongside the existing state-required Staying Healthy Assessment (SHA), Bright Futures, or another state-approved Individual Health Education Behavior Assessment (IHEBA) to improve screening for trauma in children, and examine formal integration of this tool within the SHA;
      ii) Use the Whole Child Assessment, an existing State-approved IHEBA that incorporates screening for exposure to trauma along with required elements of the SHA; and,
      iii) Request approval from DHCS to use an alternative tool to screen for trauma that includes, at a minimum, all of the items contained in the PEARLS tool.

      The ACEs Aware is an initiative led by the Office of the California Surgeon General and the DHCS to give Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs. DHCS is responsible for implementing Medi-Cal payments to providers to deliver ACEs screenings for children and adults under age 65 in the Medi-Cal program. The AB 340 Workgroup recommended that DHCS include the PEARLS tool as a complementary screening component along with the existing SHA, Bright Futures, or another approved IHEBA to improve trauma-screening practices immediately. The Workgroup encouraged the Legislature to explore systems that support trauma screening for adults in the future. Screening for ACEs has become a Medi-Cal covered benefit, effective for dates of service on or after January 1, 2020. Medi-Cal has begun reimbursing for ACEs screenings for both children and adults up to 65 years of age, except for those dually eligible for Medi-Cal and Medicare Part B, with Proposition

56 funds. Individuals under 21 years of age may receive periodic rescreening as determined appropriate and medically necessary, but screenings will not be paid more than once per year, per provider. Screenings for individuals 21 years of age and older will be paid once in their lifetime, per provider. ACEs screenings will be reimbursed at $29 per screening in both the fee-for-service and managed care delivery systems.

b) **ACEs**. According to CHBRP, ACEs are potentially traumatic events that occur any time before adulthood. There are a large number of events that may qualify as an adverse childhood experience. The original ACE Study Questionnaire examines the impact of originally seven, then expanded to 10 ACEs in the three categories below (abuse, neglect, and household dysfunction) with later modification. The 10 ACEs commonly described are events or patterns of:

i) Abuse (3: physical, emotional/psychological, and sexual);
ii) Neglect (2: physical and emotional); and,
iii) Household dysfunction (5: parental loss by divorce, abandonment or death; parental incarceration; adult-on-adult violence; adult mental illness; adult substance use disorder)

Recent studies have identified additional possible ACEs to include for screening, such as peer victimization, isolation from peers, peer rejection, property victimization, racial discrimination, exposure to community violence, death or serious illness of a close relative, low socioeconomic status and experience with the foster care system while growing up.

c) **ACEs and Health Outcomes.** ACEs include potentially traumatic events that could contribute to the development of a toxic stress response. While it is unclear exactly how toxic stress impacts the brain and body, there is evidence that suggests that ACEs make the individual more susceptible to later illness. A number of studies have associated high ACE scores with a range of outcomes at the population level. ACEs have been described as having a dose-response effect where higher ACE scores were more strongly associated with poor health outcomes. In adults, having four or more ACEs was associated with increased levels of: depression, post-traumatic stress disorder, smoking, alcohol and drug abuse, chronic obstructive pulmonary disease, asthma, kidney disease, stroke, coronary heart disease, and lower levels of employment. For children, having two or more ACEs has been associated with poor health, sleep disturbance, somatic complaints, reduced cognitive ability, childhood obesity, asthma symptoms and hospitalization, higher likelihood of being bullied, higher probability of affected males perpetrating bullying, reduced levels of school engagement, and being more likely to repeat a grade in school. Children with special health care needs were twice as likely to report experiencing two or more ACEs than children without such needs. Although ACEs are associated with a high number of negative health outcomes at a population level, screening for ACEs has not yet shown an ability to predict risk for negative health outcomes on an individual basis. While health conditions associated with ACEs can precede, coincide with, or follow ACEs occurring; CHBRP notes that none of these studies have identified a direct, causal link between an ACE and health outcome. Without a causal link, it is difficult to determine to what degree ACEs alone have an impact on individual health, as opposed to other potential factors such as socioeconomic status, poverty, pre-existing conditions. Additionally, the health consequences of ACEs may not become apparent in an

individual until many years after the experience has occurred.

d) Screening Tools for ACEs (Clinical, Research and Population Health Use). According to CHBRP, although discussion of ACEs and social determinants of health are part of comprehensive care according to the biopsychosocial model, ACEs screening is by structured screening using an ACEs screening tool during a clinical visit for the purpose of identifying individual patients who might be at risk for poor health outcomes due to ACEs, and were not otherwise noted to have ACEs. ACEs tools are designed to identify specific ACEs, however which ACEs are screened for depends on the tool used at the time of the visit. Available structured screening tools vary in the types and number of ACEs assessed, but generally are derived from the original 10 ACEs identified by the original ACEs Study: psychological or emotional abuse, physical abuse, sexual abuse, neglect, and household dysfunction. Tools are available that are primarily designed for clinical use, population health surveillance, research use, or a combination. Screening tools have been developed for adult patients to self-report certain experiences from their childhoods. Screening tools for children under the age of 12 are completed via parent report, and for teenagers aged 12-19 through combined self and parent report. All of the tools listed below use a raw total for each individual item experienced (regardless of frequency, severity, or number of possible ACEs available in the tool) to determine whether or not a person may be at higher risk for later negative health outcomes. Each item is weighted equally (counted as one ACE.) Scores between different tools are not necessarily equivalent as each tool handles ACE types differently; sometimes splitting or merging topics or including expanded options; which can result in different numbers of ACE items included depending on the tool being used. Screening for ACEs can occur at any time, however currently, DHCS recommends that questionnaires be completed by adult patients at least once in their lifetime for each primary care provider they interact with. For children and teenagers, screening is recommended annually. For children, the screening form is completed by the caregiver at the visit, and this caregiver might be responsible for the ACEs. Completing the questionnaire also requires that the caregiver have knowledge and/or insight of the ACEs occurring (such as knowing that sexual abuse by another adult is occurring, parent choice of punishment constitutes physical abuse, or the child feels emotionally neglected) plus a willingness to disclose this to the provider. In the case of teenagers, both the caregiver and the child can complete the screening forms. Pediatric screening for ACEs reflects either what has occurred or is actively occurring, with the goal to prevent future ACEs by improving parenting and household dynamics. Screening for adults reflects what occurred during childhood, with the goal of better understanding potential causes for current health status, future health risks, and potential referral to interventions targeted at healing trauma rather than biomedical care only.

e) CHBRP analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states the following in its analysis of this bill:

i) **Enrollees covered.** For this analysis, CHBRP used data published by the California Office of the Surgeon General and DHCS on its ACEs Aware program for Medi-Cal providers to estimate potential utilization change among providers in commercial plans/policies. The ACEs Aware program provides Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs. This bill appears to be structured similar to the ACEs Aware program in terms of providing reimbursement for ACEs screening. CHBRP has made an overarching assumption in this analysis that commercial plans/policies would cover ACEs screening the same way it is covered for Medi-Cal providers in the ACEs Aware program. Utilization data from the rollout of the ACEs Aware program in 2020 provide a basis for estimating utilization for the commercial plans/policies impacted by this bill. CHBRP has assumed that reimbursement for ACEs screenings by DMHC- and CDI-regulated plans and policies would be made at the same level as that set by DHCS in its ACEs Aware program at $29 per screening. CHBRP has also assumed that ACEs screenings would be conducted via in-person and telehealth visits. At baseline, CHBRP estimates that currently, 36% of enrollees with health insurance that would be subject to this bill have coverage for ACEs screening — all of these are enrollees in Medi-Cal Managed Care Programs. DHCS provides reimbursement to providers completing ACEs screenings in Medi-Cal Fee-for-Service and Managed Care. Postmandate, 100% of all enrollees with health insurance that would be subject to this bill would have coverage for ACEs screening.

ii) **Impact on expenditures.** CHBRP has assumed $29 reimbursement per each ACEs screening for commercial plans/policies. Under this assumption, this bill would increase total net annual expenditures by $36,060,000, or 0.03%, with no projected cost offsets.

   (1) **Medi-Cal**. CHBRP has assumed no new fiscal impact to Medi-Cal Managed Care Plans due to the present availability of reimbursement for ACEs screening through DHCS, which is funded via an annual state appropriation.
   (2) **CalPERS**. CHBRP projected an estimated $1,983,000 impact, or 0.03%, for CalPERS HMO employer expenditures.
   (3) **Number of Uninsured in California.** CHBRP expects no measurable change in the number of uninsured persons due to the enactment of this bill since the change in average premiums does not exceed 1% for any market segment.

iii) **EHBs.** Currently, there is no requirement in the federal Medicaid statute to screen for trauma in adults. Medicaid-eligible children are entitled to interperiodic screenings in order to identify a suspected illness or condition not present or discovered during the periodic exam. CHBRP does not believe that this bill requires coverage for a new state benefit mandate that exceeds the definition of essential health benefits in California. CHBRP's conclusion is based on two considerations: the first being that this bill would affect the terms and conditions of existing coverage (additional reimbursement for a specific completion of the screening tool for a visit already covered); and second, this bill impacts reimbursement for a habilitative screening tool that is used to assess referral for needed mental health and ambulatory care services.

iv) Medical effectiveness. According to CHBRP, the literature regarding the impact of ACEs screening tools is limited. CHBRP was not able to identify any head-to-head comparisons of ACEs screening tools. The lack of such comparisons prevents CHBRP from assessing whether some ACEs screening tools are better than others. Additionally, there is very little literature on the impact of screening programs for referrals for services, use of services, or health outcomes. CHBRP states that studies that assessed the validity and reliability of ACEs screening tools were included because ACEs screening is only beneficial if it can accurately (validity) and consistently (reliability) identify people at elevated risk for bad outcomes and if there are effective interventions to reduce risk. The gold standard for screening is demonstrating that screening improves health outcomes by identifying and treating people at an elevated risk before they develop illnesses or their symptoms become severe. CHBRP's Medical Effectiveness review reached the following conclusions regarding ACEs screening:

(1) Psychometric Properties of ACEs Screening Tools

- **(a)** There is *limited evidence* that ACEs screening tools that screen children demonstrate face validity and concurrent validity;
- **(b)** There is *insufficient evidence* that ACEs screening tools that screen children demonstrate predictive validity;
- **(c)** There is *insufficient evidence* that ACEs screening tools that screen adults demonstrate convergent validity;
- **(d)** There is *limited evidence* that ACEs screening tools that screen adults demonstrate predictive validity;
- **(e)** There is *limited evidence* that ACEs screening tools that screen adults demonstrate internal consistency reliability;
- **(f)** There is *limited evidence* that ACEs screening tools that screen adults demonstrate test-retest reliability;
- **(g)** There is *insufficient evidence* to determine whether shorter versions of ACEs screening tools that screen adults or children have levels of sensitivity and specificity that are similar to those of longer screening tools.

(2) Availability of Effective Interventions to Address the Effects of ACEs

- **(a)** There is a *preponderance of evidence* that there are effective home visiting interventions for children who experience ACEs;
- **(b)** There is *limited evidence* that there are effective low-intensity interventions for children who experience ACEs;
- **(c)** There is *insufficient evidence* that there are effective interventions for adults who experience ACEs.

(3) Impact of ACEs Screening on Referrals and Use of Services

- **(a)** There is *limited evidence* that ACEs screening increases referrals to community resources and decreases Child Protective Services (CPS) reports for children;
- **(b)** There is *insufficient evidence* on the impact of ACEs screening on referrals to community resources for adults;
- **(c)** There is *insufficient* evidence on the impact of ACEs screening on referrals to health services for children and adults;
- **(d)** There is *insufficient evidence* to determine whether ACEs screening affects health care services utilization for children or adults.

(4) Impact of ACEs Screening on Health Outcomes

(a) There is *limited evidence* that ACEs screening improves health outcomes for high-risk children, and *insufficient evidence* on the impact of ACEs screening on the health outcome of low-risk children and adults.

(5) Harms Associated With ACEs Screening

(a) There is *insufficient evidence* to determine whether ACEs screening harms children or adults.

iv) **Utilization.** CHBRP has assumed the following postmandate utilization of ACEs screening due to this bill among enrollees in commercial plans/policies: 15% of enrollees under 18 years and 5% of adults 18 to 65 years screened in year 1. Under this assumption, CHBRP estimates an increase in 1,038,648 enrollees receiving ACEs screening postmandate.

iv) **Public health.** In the first year postmandate, a public health impact of this bill is expected for the subset of the children aged 0–5 years who are able to access effective interventions after ACEs screening. CHBRP is unable to estimate patterns of ACEs screening or access to effective interventions by individual gender, race, or sexual orientation. CHBRP concludes that the impact of this bill on disparities in health outcomes by gender, race/ethnicity, or sexual orientation is unknown. There is not enough evidence available to determine whether the process of screening for ACEs has an effect on public health outcomes or health care utilization. Although utilization of ACEs screening will likely rise, it is unclear whether those who do receive screening and are considered high risk will have access to effective interventions. When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. Potential harms associated with the use of ACEs screening include discomfort sharing sensitive information and concerns about potential risks from disclosing ACEs. Qualitative studies have demonstrated that pediatric screening for ACEs is acceptable to families, as long as an integrated model of care with relevant and accessible services is in place prior to screening.

iv) **Long-term impacts**. It is possible that screening will increase over time as provider and patient awareness of ACEs and interest in trauma-informed care and addressing social needs grows. However, CHBRP posits that ACEs screening uptake is likely to be curbed by the limitations of ACEs screening and the ability to refer to effective interventions. Given that the body of literature on potential harms and benefits is still growing, CHBRP is unable to estimate the degree to which ACEs screening will be taken up by providers over time. The long-term public health impacts are unknown.

f) Other states. According to CHBRP, though legislatures across the country have shifted focus to respond to COVID-19, more than 35 states introduced legislation on ACEs in 2020. Since January 2019, at least 26 states enacted or adopted legislation to address childhood trauma, child adversity, toxic stress, or ACEs specifically. Many bills create a new task force or commission, implement workforce training on ACEs or trauma-informed practices, or strengthen behavioral health supports for children. A half dozen states have introduced legislation to require coverage mandates for their Medicaid programs and/or commercial health insurers to provide coverage for ACEs screenings/assessments. Several states formed task forces or similar groups to consider

strategies that fit their communities. For example, Indiana established a behavioral health commission to assess mental health issues, including childhood trauma and suicide, and to identify barriers to treatment. Last year, Hawaii established a task force to create a system for evaluating and assessing all children and those who are exhibiting emergent or persistent behaviors, academic challenges, or chronic absenteeism and are in need of appropriate supports and interventions accessible within the continuum of a multi-tiered system of supports. West Virginia and Washington created similar groups. Other states are targeting treatment to lessen the harms of ACEs and help children build healthy coping strategies. In 2019, Colorado enacted the K-5 Social and Emotional Health Act, which places a social worker in each grade in up to 10 pilot program schools. Due to COVID-19, its implementation has been delayed. A 2019 Oklahoma law directed state departments to develop training guidelines to help school employees recognize and address the mental health needs of students, including information about the impact ACEs can have on a student's ability to learn, and resources on mental health services.

3) **SUPPORT**. Children Now and California Medical Association, cosponsors of this bill, write that the groundbreaking ACEs study demonstrated that a child's exposure to traumatic events substantially impacts their long-term health. The findings make identifying a child's exposure to abuse, neglect, discrimination, violence and other adverse experiences—and connecting children and families to early intervention services that can help families heal from trauma or slow or reverse the expected negative health outcomes—a core component of health care. Screening children and adults for exposure to adversity can help practitioners identify those at high risk for experiencing toxic stress (frequent and/or prolonged activation of a stress response due to adversity or trauma). Screening in primary care settings can help prevent further exposure to adverse experiences, and—when a strong referral system is in place—can provide appropriate education for parents and caregivers about the relationship between early adversity and negative health outcomes. For example, screening can inform a pediatrician's care plan by identifying children who are at high risk for health problems due to toxic stress, which may be an underlying cause of clinical symptoms. By identifying and intervening, there is an opportunity to reverse the neurological and physical effects of severe adversity that are common when not addressed early. Currently, California provides the trauma screening benefit for Medi-Cal beneficiaries. This approach has the potential to pathologize poverty, as only low-income families are asked about their adverse childhood experiences, a practice that is not supported by research. Without expanding this screening benefit into the commercial market, California will continue to limit the ability for all families at risk for toxic stress to receive targeted interventions that can reduce the risk of chronic disease later in life. The COVID-19 pandemic has been a stressful and traumatic time for most, and is considered a traumatic event for the broader population. However, without universal screening, it is likely the State will under identify those who suffer from toxic stress. The sponsors state that this bill will allow providers to identify individuals' trauma histories, provide necessary services early, and reduce the risk of racial/ethnic and socioeconomic bias. Many experts have warned that the current COVID-19 pandemic is a traumatic stressor and that the long-term mental and physical impacts of the pandemic have yet to be understood. Expanding screening coverage now will enable physicians to mitigate what would otherwise become compounding trauma, ultimately reducing long-term costs in the healthcare system.

4) **OPPOSITION**. The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health

Insurance Plans (AHIP) write that mandate bills will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. CAHP, ACLHIC, and AHIP state that benefit mandates stifle the use of innovative, evidence-based medicine and prevent benefits packages from adapting to evolving medical literature and clinical guidelines to provide the most up-to-date and cost-effective products to consumers.

5) PREVIOUS LEGISLATION.

a) AB 74 (Ting), Chapter 23, Statutes of 2019, appropriates Prop 56 funding for ACEs screening in Medi-Cal among many other budgetary appropriations.

b) AB 340 (Arambula) requires that screening services provided under the EPSDT Program include screening for trauma, defines trauma for the purpose of screening, and requires the DHCS, in consultation with the DSS, behavioral health experts, child welfare experts, and stakeholders, to adopt, employ and develop tools and protocols for the screening of children for trauma, as specified.

6) AUTHOR'S AMENDMENTS. The author wishes to clarify that DMHC and CDI may issue guidance, without taking regulatory action, until the time regulations are adopted.

REGISTERED SUPPORT / OPPOSITION:

Support

Children Now (cosponsor)
California Medical Association (cosponsor)
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District Ix
American Nurses Association/california
California Academy of Family Physicians
California Children's Hospital Association
California Medical Association
California School-based Health Alliance
California State Association of Psychiatrists (CSAP)
Californiahealth+ Advocates
Children Now
Children's Specialty Care Coalition
Dbsa California
First 5 California
Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties
Junior League of San Diego
National Association of Social Workers, California Chapter
Public Health Advocates
Steinberg Institute

Opposition

California Association of Health Plans

The Association of California Life and Health Insurance Companies
America's Health Insurance Plans

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