CalAIM: California Advancing and Innovating Medi-Cal

Jacey Cooper

October 2019

CalAIM: California Advancing and Innovating Medi-Cal

DHCS has developed an comprehensive and ambitious framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal.

Includes initiatives and reforms for:

- Medi-Cal Managed Care
- Behavioral Health
- Dental
- Other County Programs and Services

Guiding Principles

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities or inequities.
- Drive system transformation that focuses on value and outcomes.
- Support community activation and engagement.
- Improve plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Implementation Goals

To achieve such principles, CalAIM has three primary implementation goals:

- Identify and manage member risk and need through population health management strategies
- Reduce variation and complexity across the system
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform

Proposal Release

Throughout 2019 and 2020, DHCS will conduct extensive stakeholder engagement for both CalAIM and the renewal of the 1115 and 1915b waiver(s).

DHCS will formally release the CalAIM proposal on October 29, 2019, at the Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) meetings and will use these venues to provide feedback on an ongoing basis, as well as to review feedback received on the waiver processes.

CalAIM Workgroups

DHCS will establish topic-specific stakeholder workgroups to further explore different sections of the CalAIM proposal.

Five workgroups covering different elements of the initiative will meet several times between November 2019 and February 2020.

Workgroups will have 20-30 assigned members.

Each CalAIM workgroup will be open to the public, so DHCS encourages interested parties to attend and/or submit written comments. Workgroup schedules, agendas, materials, and other CalAIM updates will be made available on the CalAIM webpage.

CalAIM Workgroups

- Population Health Management and Annual Health Plan Open Enrollment
- Enhanced Care Management and In Lieu of Services
- Behavioral Health
- Full Integration Plans
- NCQA Accreditation

Population Health Management and Annual Health Plan Open Enrollment

This workgroup will provide input on requiring Medi-Cal managed care plans to develop and maintain population health management strategies that address:

- initial and ongoing assessment of risk and need,
- leverage risk stratification in care planning,
- consider social determinants of health,
- ensure smooth transitions of care, and
- focus on data collection and reporting.

This workgroup will also provide input on a proposal to move to annual Medi-Cal health plan open enrollment.

Enhanced Care Management and In Lieu of Services

This workgroup will discuss the possibility of implementing a policy to establish an enhanced care management benefit.

An enhanced care management benefit would be designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries enrolled in requiring Medi-Cal managed care plans . Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals.

Enhanced Care Management and In Lieu of Services, cont.

DHCS is seeking input regarding the possibility of including “in lieu of" services, which are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management strategy.

- These services are provided as a substitute, or to avoid, other services, such as a hospital or skilled nursing facility admission, discharge delay, or other.
- In lieu of services should be integrated with case management for members at high levels of risk and may fill gaps in State Plan benefit service to address medical or social determinants of health needs.

Behavioral Health

This workgroup will provide input on

- Opportunities and challenges in integrating county-level mental health and substance use disorder programs under a single contract
- Proposed changes to the reimbursement structure of county-level mental health and substance use disorder services
- Proposed revisions to the medical necessity criteria for behavioral health services
- The possibility of pursuing the mental health IMD waiver opportunity which would allow counties to receive federal reimbursement for services furnished to Medicaid eligible adults with serious mental illness and children with serious emotional disturbance in an IMD.

Full Integration Plans

This work group will provide input on a pilot to test the effectiveness of full integration of physical health, behavioral health, and oral health under one entity.

This component of CalAIM will be meeting later in the process, as it has a longer implementation timeline.

NCQA Accreditation

This workgroup will provide input on topics related to standards for and the process of requiring Medi-Cal managed care plans to obtain NCQA accreditation, including consideration of the proposed accreditation requirements. Workgroup members will be asked to provide feedback on the NCQA Medicaid module, the long-term services and supports distinction survey, and accreditation deeming policies.

Benefit Changes

Effective January 1, 2021, DHCS will:

- Carve in long-term care and coverage of transplants to become the responsibility of all Medi-Cal managed care plans statewide, and
- Carve out the Multipurpose Senior Services Program (MSSP) benefit from the Coordinated Care Initiative in all seven counties of operation.

Additional details pertaining to this announcement can be found in this memo.

Stay Informed

Please subscribe to DHCS' stakeholder email service to receive CalAIM updates.

For any other comments, questions, or concerns, please contact CalAIM@dhcs.ca.gov.

CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

Success and Future of 1115 Medicaid Waivers in CA

Erica Murray, President and CEO
CPCA Conference
October 17, 2019

Agenda

- Who We Are
  - California Association of Public Hospitals and Health Systems (CAPH)
  - California Health Care Safety Net Institute (SNI)
- Medi-Cal 2020 Waiver
  - Whole Person Care
  - Global Payment Program
  - PRIME
- Implications and Risks

California's Public Health Care Systems

California's 21 public health care systems

- Serve more than 2.85 million patients annually in 15 counties (80% of the state's population)
- 500,000 Medicaid enrollees, roughly 35% of all hospital care to Medicaid beneficiaries in these communities
- 40% of all hospital care to the remaining uninsured
- 200 outpatient clinic facilities and over 10 million outpatient visits each year

Alameda County
Alameda Health System

Contra Costa County
Contra Costa Health Services:
- Contra Costa Regional Medical Center

Kern County
Kern Medical

Los Angeles County
Los Angeles County Department of Health Services:
- Harbor/UCLA Medical Center
- LAC+USC Medical Center
- Olive View / UCLA Medical Center
- Rancho Los Amigos National Rehabilitation Center

Monterey County
Natividad Medical Center

Riverside County
Riverside University Health System

San Bernardino County
Arrowhead Regional Medical Center

San Francisco County
San Francisco Department of Public Health:
- Zuckerberg San Francisco General Hospital
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin County
San Joaquin County Health Care Services:
- San Joaquin General Hospital

San Mateo County
San Mateo Medical Center

Santa Clara County
Santa Clara Valley Health & Hospital System:
- Santa Clara Valley Medical Center

Ventura County
Ventura County Health Care Agency:
- Ventura County Medical Center

University of California (UC)
UC Health:
- UC Davis Health
- UCI Health
- UC San Diego Health
- UCSF Health
- UCLA Health

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California Health Care Safety Net Institute

- Supports California's public health care systems in their efforts to improve the way they deliver care by:
  - Informing and shaping statewide and national health care policy
  - Providing performance measurement and reporting expertise
  - Accelerating and supporting decision-making and learning across systems

SNI California Health Care Safety Net Institute

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Medi-Cal 2020 Waiver

- Why waivers are important to public health care systems:
  - Low base rates
  - Self-financed array of supplemental payments, including the waiver
  - Still doesn't cover costs
  - Inability to cost shift

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Medi-Cal 2020 Waiver

- Public health care systems' 3rd five-year 1115 Medicaid waiver
- ~$6 billion over 5 years in federal funding, matched with public health care system financing
- Represents 18% of total revenue
- Entirely self-financed by public health care systems
- Expires next year (2020)

Four Programs

- Whole Person Care Pilots (WPC)
- Global Payment Program (GPP)
- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
- Dental Transformation

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Uncertain Future

- CMS disallowing CA's approach to budget neutrality ➡ much smaller 1115 waiver renewal
- Public health care systems face a funding crisis with the expiration of the Medi-Cal 2020 waiver
  - Total potential revenue losses: $2.1 billion net
  - Increase in net uncompensated costs: ~$1.1 billion net
  - Grand total potential impact: ~$3.2 billion net
- Looking to a variety of sources to replace losses and address uncompensated costs:
  - No one single solution
  - No guarantees for any of them, requires CMS approval
  - Varied timing

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Whole Person Care (WPC)

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Background

- Five-year pilot program within 1115 Medi-Cal Waiver, $300M in federal funds annually
- Premised on the concept that the best way to care for complex patients is to address their holistic needs
  - Providing "whole person care": addressing medical, behavioral, emotional, and economic needs
  - Bringing together health, behavioral health, social services, and community partners to care for high-risk, high-utilizing clients
  - Offering tailored support and coordinated services so that patients can ultimately enjoy healthier lives
- Partnerships are critical: Medical / legal, behavioral health / law enforcement, county / community-based organizations
- Key services and interventions include:
  - Homeless outreach
  - Diversion/step down
  - Housing and supportive services
  - Community re-entry
  - Psychiatric emergency
  - Intensive case management/care coordination

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Whole Person Care (WPC)

Jeanna's Story

Whole Person Care Pilot, Ventura County

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Successes

- Pilots continue to develop and refine cross-sector infrastructure
  - Over 100k enrolled statewide
- 75 % of pilots opened or expanded:
  - Post-acute facilities and/or temporary housing
  - Medical and psychiatric respite
  - Low- threshold homeless shelters with on-site intensive case management and transitional housing units
- Across 12 pilots, over 190 partner organizations are collaborating to coordinate care for enrollees, including:
  - Housing providers
  - Homeless advocates
  - Social service agencies
  - Behavioral health departments
  - Food banks
  - Corrections departments
  - Among others…

Photo: Community Health Worker and Client, LA Whole Person Care

- Program bringing to light and addressing core issues:
  - Data sharing/privacy
  - Medi-Cal re-enrollment
  - Duplication of care coordination

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Lessons Learned

- **Focus the energy on cross-sector collaboration**
  - WPC is the "connective tissue"
  - Siloed financing and data systems don't inherently incentivize this work
- **Funding flexibility is hugely important**
  - Pay for whatever is needed for the patient, organizationally at the local level
- **Data sharing rules, primarily perceptions, are a barrier**
  - Largely the answer is to get patient consent
  - Can feel the lack of a statewide HIE
- **Intensive care coordination is the key**
  - One-on-one established relationships with high-risk patients
  - This is not your managed care plan care management
- **Work takes time**
  - We have barely begun, and any future evolutions of this work need to be carefully mapped out and intentionally and robustly supported

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Looking Ahead

- WPC funding will transition to payment through managed care plans: In Lieu of Services (ILOS) and Enhanced Care Management (ECM)
- Policies that smooth the pathway for contracting between WPC pilots, counties, and managed care plans is essential
- Incentives will be needed to help encourage managed care plans to aggressively implement ECM benefits and new ILOS, such as housing support

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Global Payment Program (GPP)

Global Payment Program (GPP)

- Five-year program within the 1115 Medi-Cal Waiver, $1.1B annually
- Specifically targets uninsured patients
- Goal: Provide right care in the right place at the right time
  - Aims to shift care from emergency department and inpatient settings to more appropriate care in outpatient settings, including the provision of non-traditional services
  - Created a "points" system to incentivize public health care systems to deliver care in more appropriate settings

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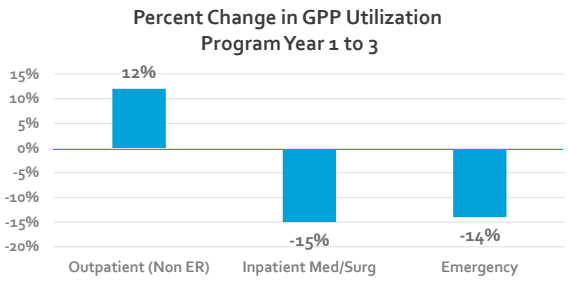
Successes

- Utilization of services is trending in the right direction
  - Majority of public health care systems increased utilization of outpatient services, and reduced emergency and inpatient utilization
- Points from non-traditional services increased by 42%
- Number of estimated unique uninsured patients served increased by over 6%



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Lessons Learned

- **Funding flexibility helps create incentives to be more efficient:**
  - Ability to provide services outside of the hospital setting:
    - Mobile wellness events
    - Local churches
    - Street outreach for homeless
    - Community health workers visit schools and community events
  - Ability to pay for non-traditional services:
    - Telehealth
    - E-Consults
    - Health Coaching
    - Phone visits with nursing staff

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Looking Ahead

- GPP renewal is a must… and a question
- Renewal requires approval from the federal government in 2020
- Even as coverage expansion efforts rollout across California, there is still a strong need for high-quality, timely, appropriate, cost-effective health care services for the remaining uninsured

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Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

Background

- Five-year pay-for-performance program within the 1115 Medicaid waiver. Funding declined overtime – last year: $535M in federal funds
- Year-over-year performance improvement targets
  - 10% gap closure between current performance and 90th percentile benchmarks
  - Must be above 25th percentile to receive payment
  - Performance above 90th percentile must be maintained
- Total number of metrics for a public health care system ranges from 56-80 metrics
  - Includes 80% standard (e.g., national/state) measures and 20% innovative, piloting measurement of new, transformative care practices
- Clinical domains
  - Outpatient delivery system transformation and prevention
  - Targeted high-risk or high cost populations
  - Resource utilization efficiency

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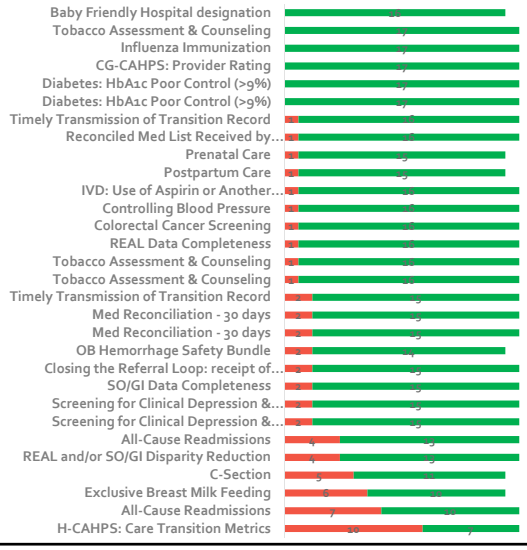
Successes

Target Met – Year 3



Addressing Disparities Spotlight

Figure 1. REAL Data Collection (Years 1-3)*

Figure 2. SOGI Data Collection (Years 2-3)*

*Each vertical bar represents one health care system

# of DPHs that met or exceeded DY13 YE target

# of DPHs that did not meet or exceed DY13 YE targets

Lessons Learned

- **Huge gain in delivery system transformation, but more work to be done**
- **Significant incentives to improve quality yield significant improvements**
- **Standardization**
- **Requires robust technical support essential to success**
  - Measure specifications
  - Data reporting
  - Learning collaboratives and feedback loops
- **Tradeoff between more measures vs. more funding per measure**

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Looking Ahead

- Seeking to combine PRIME with another performance-based supplemental payment program, the Quality Incentive Program
- Strengthened alignment with state and plan CMS Core Reporting via the Managed Care Accountability set

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Implications and Risks

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Implications and Risks

- Uncertainty on top of uncertainty
  - Survival is a question for some public health care systems
- Appreciate the partnership with the State and others in finding viable funding alternatives to the waiver
- Greater reliance on managed care plans: some relationships already strong, others less so
- Even higher expectations regarding performance
- Will continue to be self-financed, with the limitations that go along with that approach

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FUTURE CHANGES TO MEDI-CAL: SPECIALTY MENTAL HEALTH & SUD SERVICES

Michelle Doty Cabrera, Executive Director

County Behavioral Health Directors Association of California (CBHDA)

mcabrera@cbhda.org

www.cbhda.org

October 17, 2019

POPULATIONS SERVED

All Ages

Medi-Cal

Specialty Mental Health

Substance Use Disorder

EPSDT

Also:

Uninsured

Commercially Insured

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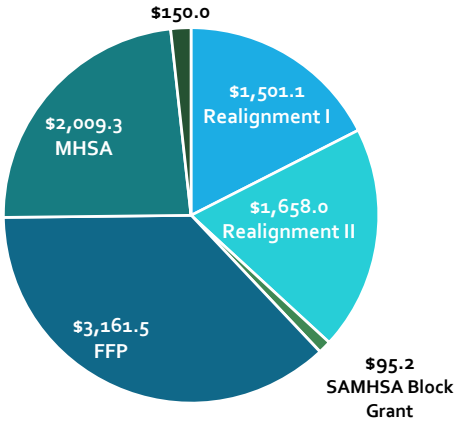
BEYOND MEDI-CAL

- All Populations, *regardless of insurance* – obligation to serve
  - **Mental Health Crisis Services**
- All Populations *when funding available*
  - Mental Health Services Act (Prop 63)
  - SAMHSA Grants
  - Public Safety Realignment (AB 109)
  - Proposition 47 Grants (for criminal justice-involved)

Local Mental Health Funding Levels

Projected 2019-20, MHSOAC data



>$8 billion total funds via:

- Federal Financial Participation ($3 billion)
- 1991 Realignment ($1.5 billion)
- 2011 Realignment ($1.7 billion)
- MHSA ($2.4 billion)

Total Medi-Cal ~$100 billion

Medical

Medications

Relevant physical health conditions

Psychosocial

Living situation

Daily activities

Social support

Cultural and linguistic factors

MODELS OF CARE

COUNTY BEHAVIORAL HEALTH: PLAN & PROVIDER

CURRENT WAIVERS

- 1915 (b) Waiver
  - Specialty Mental Health (Children & Adults)
  - Drug Medi-Cal State Plan
- 1115 Waiver
  - Drug Medi-Cal Organized Delivery System (ODS)
  - Whole Person Care Pilots

COUNTY MENTAL HEALTH

MEDI-CAL SPECIALTY MENTAL HEALTH

- In 1995, CA received federal Section 1915(b) "Freedom of Choice" waiver to provide "Specialty Mental Health".
  - Currently under the 9th waiver renewal (July 1, 2015 - June 30, 2020)
- DHCS Oversight of 56 county mental health plans
  - Prepaid inpatient health plan (PIHP)
  - Must meet Managed Care Final Rule requirements

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SPECIALTY MENTAL HEALTH FEATURES

Not clinic based: can be mobile and offered in community settings, including home or school

A wide variety of eligible providers (>15 types)

Individualized, driven by a client's treatment plan

Culturally and linguistically appropriate

Least restrictive environment

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WHO QUALIFIES? (EST. 1997 – CA REGULATIONS)

1. Must have a **covered diagnosis**
2. Must have **at least one** of the following **impairments**
   - A significant impairment in an important area of life functioning
   - A reasonable probability of significant deterioration in an important area of life functioning
   - The beneficiary has a condition that would not be responsive to physical health care based treatment
3. The focus of the proposed **intervention** is to address the identified impairment(s) above.

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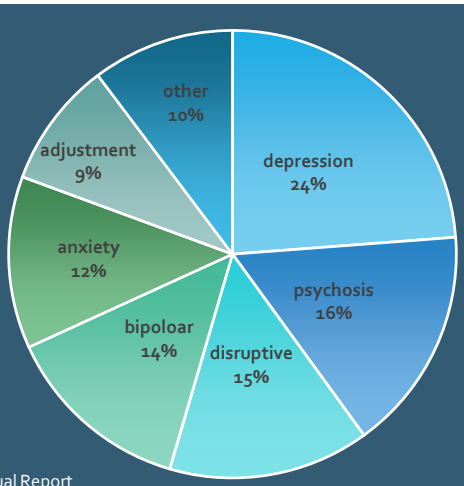
MEDI-CAL POPULATION SERVED, BY DIAGNOSIS



Source: CA EQRO 15/16 Annual Report

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WHAT ARE "SPECIALTY" MENTAL HEALTH SERVICES?

- Mental health services
  - Assessment
  - Client plan development
  - Rehabilitation
  - Collateral
  - Individual and group therapy
- Crisis intervention
- Crisis stabilization
- Residential services
- Day treatment
- Case management
- Medication support
- Inpatient services
  - For all Medi-Cal beneficiaries

Source: Rehabilitative MH Services State Plan Amendment, 12-025
Targeted Case Management State Plan Amendment, 10-021A

MEDI-CAL CHILDREN'S COVERAGE

County Medi-Cal responsibility

Medi-Cal children who meet specialty mental health medical necessity criteria

Broader definition of "medical necessity" than for adults

Must have:

- A covered diagnosis,
- A condition that would not be responsive to physical health care based treatment; and,
- Services necessary to correct or ameliorate a metal illness and condition discovered by screening

EARLY AND PERIODIC SCREENING, DIAGNOSIS & TREATMENT (EPSDT)

Medi-Cal enrollees who meet medical necessity criteria must access EPSDT ***specialty mental health*** services through their local county mental health plan

Collaboration with schools and families

Schools may refer children to the county	Mobile mental health, rehabilitative, and case management services may be provided at home and/or on school sites by counties and subcontract providers

SERIOUS EMOTIONAL DISTURBANCE

Under age 18 if child has an identified mental disorder that results in behavior inappropriate to the child's age, and either:

- Has substantial impairment in at least 2 areas (self-care, school functioning, family relationships, ability to function in the community) and either:
- Is at risk of removal from the home or has already been removed, or
- The mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment

Displays psychotic features, risk of suicide or risk of violence due to the mental disorder

(See Bronzan McCorquodale Act, 5600.3)

ADVERSE CHILDHOOD EXPERIENCES

- Acknowledges demonstrated link between behavioral health and physical health
- Need to broaden definition of medical necessity
  - ***In Los Angeles, County Mental Health covers trauma-related services not meeting medical necessity via MHSA funds***
- Bring interventions upstream to focus on prevention/early intervention
  - Schools
  - Child welfare system
  - Multi-generational approach

INVOLUNTARY TREATMENT

- Lanterman-Petris-Short Act (e.g. 5150 holds) - Only when a person, due to a mental disorder, poses harm to their self or others, or is gravely disabled
- Hospitalizations (State Hospitals, IMD placements, Conservatorship, Forensic)
- Assisted Outpatient Treatment (Laura's Law)
- Jail treatment
- Incompetent to Stand Trial
- Specialty Courts

SUBSTANCE USE DISORDER SERVICES

DRUG MEDI-CAL (DMC)

Fee-for-service Medi-Cal specialty carve-out entitlement program

Services must be medically necessary and provided by or under the direction of a physician

DMC ORGANIZED DELIVERY SYSTEM (DMC-ODS) GOALS

- Improve Substance Use Disorder services
- Reduce emergency rooms and hospital inpatient visits
- Ensure access to SUD services
- Increase program oversight and integrity
- Place clients in the least restrictive level of care
- Support coordination and integration across systems
- Use evidence-based practices to improve client outcomes
- Give counties ability to selectively contract with treatment providers

DMC Services	SPA 13-038 (Non-Waiver)	Opt-in Waiver
Outpatient/Intensive Outpatient	X	X
NTP	X	X
Residential	Perinatal, non-IMD	X (one level)
Withdrawal Management		X (one level)
Recovery Services		X
Case Management		X
Physician Consultation		X
Additional MAT		X (optional)

DMC-ODS WAIVER/ NON-WAIVER

ADDITIONAL DMC-ODS SERVICES

- Recovery Services
  - ✓Outpatient counseling (individual or group)
  - ✓Recovery monitoring & coaching
  - ✓Peer-to-peer services & relapse prevention
  - ✓Education & job skills
  - ✓Family support
  - ✓Support groups
  - ✓Ancillary services, with linkages to **supportive housing assistance**, transportation, & case management.

HOUSING/HOMELESSNESS

- Mobile/Community Based Homeless Outreach
- Supportive Housing/Housing Placements
- Whole Person Care Pilots
- Payment "patches" to board and care facilities
- Street treatment
- Full-Service Partnerships

CHALLENGES

Delivery System

- Aging workforce/severe shortages in certain specialties
- Challenges with serving subpopulations (e.g. justice-involved, involuntary)

Outdated and Inefficient Medi-Cal Reimbursement Model

- Providers must document services *by the minute*
- Significant and unnecessary audit risk tied to initial assessment

Lack of Integration

- Mental health and substance use disorder services
- Physical health

Medical Necessity Criteria

- Blurry lines and audit risk

Inadequate Private Coverage/System of Care

PRINCIPLES FOR TRANSFORMATION

- Consumer/family voice & choice
- Strengthen the safety net – esp. role of counties as purchasers, coordinators, and providers of quality, community-based care
- Offer rehabilitative services and supports that are:
  - Recovery-oriented
  - Responsive to the cultural values of California communities
  - Trauma-informed
  - Community-based, via homes, schools, and other accessible locations
  - Earliest possible point of intervention (trauma?)
  - Responsive to the complex, cross-system needs of consumers

PRINCIPLES FOR TRANSFORMATION (CONT.)

- Whole person care approach that addresses the social determinants of health, including housing
- Eliminate barriers to addressing co-occurring substance use disorder and mental health needs
- Reduce the complexity for consumers and families in navigating access to services
- Support collaboration among different types of organizations serving behavioral health consumers
- Provide measurable outcomes to the public and decision makers

STRATEGIES

- Payment Reform
- Modernize Medical Necessity
- Emphasize prevention/population health
- Strengthen partnerships across multiple public systems
- Delivery system transformation
  - Workforce investments
  - Quality Improvement
  - SMI/SED IMD Waiver
  - Expansion of Drug Medi-Cal ODS
  - HCBS Waiver
  - Integration across multiple systems

Michelle Doty Cabrera

Executive Director

California Behavioral Health Directors Association

mcabrera@cbhda.org