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January 31, 2012

Peter Lee,
Executive Director
California Health Benefits Exchange
Sacramento, CA 95814

Re: Request for Input on Marketing, Enrollment & Retention

Dear Mr. Lee:

Community Health Councils (CHC), on behalf of its statewide coalition members, writes in response to the request for input on how best to *"assure maximum enrollment of eligible individuals in the Exchange, Medi-Cal and Healthy Families in 2014 and beyond."* We recognize that implementation of the Affordable Care Act (ACA) in California is no minor feat. The success of a new coordinated healthcare system relies equally on its design and marketing plan to educate individuals and the business community on new federal requirements, healthcare coverage options and changes to existing programs. We appreciate the opportunity to provide input and acknowledge your leadership in ensuring California is prepared to enroll and provide millions of newly eligible individuals and families with healthcare coverage starting January 2014.

CHC is a non-profit, community-based health promotion, advocacy and policy organization committed to improving health and increasing access to quality healthcare for uninsured, under-resourced and under-served populations in California. In an attempt to provide a statewide perspective from the health advocacy community on how to educate Californians about their eligibility for health coverage prior to January 1, 2014, CHC convened approximately 20 organizations consisting of community-based organizations, health plans, providers and county health representatives to develop the following responses to the Marketing/Outreach, Pre-Enrollment/Retention and Consumer Education questions. Please note: This is one of two documents submitted in response to the questions outlined by the Board for public comment. This particular response focuses solely on the "marketing and outreach" portions. A second, and more in-depth, brief has been submitted on the issues pertaining to the Navigator system.

We preface our recommendations by asserting that the approach should not be limited to the conventional constructs of marketing and outreach, but the strategies employed should be fully integrated into the overall systems and structure of the Exchange. Marketing and outreach must be seen as an integral component of the Exchange's ongoing effort to:

- **Inform and Increase the Public's Understanding of the ACA**: This should include the provisions under the ACA; the implementation timeline; the implications for individuals and employers; the scope of the program and services; the role of the Exchange; and transparency in the planning and development of the Exchange from beginning to end.
- **Build a "Culture of Coverage"**: For millions of individuals, families and businesses throughout California, healthcare insurance is an upper- and middle-class construct. The price of healthcare coverage has either been out of reach or the cost of insurance has outweighed the perceived benefits. Dispelling myths and misinformation and demonstrating the cost benefit of healthcare coverage must be a priority. This includes developing policies, systems and messaging that seeks to bring people into the Exchange rather than screen them out, welcomes and demonstrates diversity and inclusion.
- **Establish Name Recognition**: The Exchange and product line must be readily identifiable by the larger public in order to generate the level of participation needed to be effective and efficient. While this recognition will be developed over time, it begins with an effective outreach and marketing plan and program.
- **Build Confidence in the Exchange**: Establishing confidence and trust begins with messaging, but is intrinsically linked to the quality of customer service at all stages in the Exchange and points of access. This can only be achieved through a system of quality assurance, comprehensive training, cultural and linguistic capacity and consistent, accurate information. Confidence or the lack thereof is also generated based the quality, caliber and capacity of the network of plans and providers.
- **Convey Both Quality and Equity in the Options Available for Coverage**: Because the Exchange will be a key portal for accessing public, individual commercial and small group coverage, it is essential that there are no real or perceived differences in the quality of the program options. An increased number of individuals and families will now be eligible for Medi-Cal. It is critical that this be viewed as quality healthcare, of equivalent if not greater value than commercial plans.
- **Maximize Enrollment and Participation in the Exchange**: This should include potential individual enrollees, employers, health plans and providers. The Exchange, and by extension healthcare reform, will be successful to the degree that product lines meet the public's needs and expectations, and individuals, families and employers across socio-economic boundaries actively enroll in and effectively utilize the program.

Given this premise, we believe the approach should not be the development of a "marketing and outreach" plan but rather a "***social marketing campaign and program***" that both informs and moves the anticipated 4.7 million uninsured to seek healthcare coverage through the Exchange. To this end, we offer the following responses to the questions raised.

Social Marketing / Outreach

Additional Market Segments (Question 2): In addition to the potential market segments already noted in the "Stakeholders Request for Questions," the following markets should be a point of focus:

- Young adults. This population is not likely to purchase health insurance on their own but may be unemployed or underemployed, making them eligible for either Medi-Cal or subsidies in the

Exchange. Additionally, those who are under the age of 26 may not be aware of the ACA provision allowing them to stay on their parent's plan. An explanation of this provision should be included in all marketing aimed at young adults under 26.

- Caretakers of elderly parents. This population spans all demographics and due to caretaker obligations, this population is usually unable to obtain any type of consistent full-time employment. Additionally, members of this segment are often too young to qualify for Medicare.
- The unemployed (especially those not already linked to a public program). With an unemployment rate in California of 11.1%,[1] this population is either using or is soon to run out of COBRA benefits, paying on a fee-for-service basis for healthcare or delaying care because of the cost. Because of their lack of employment, this population would be eligible for Medi-Cal or subsidies in the Exchange.
- The under-employed and self-employed (e.g., laborers/handymen, domestic workers, clerks, restaurant workers and owners of small retail stores). Many of these individuals are not likely to afford health coverage and where some may receive healthcare for their children via public programs, their income could put them over the current income level for eligibility in Medi-Cal.
- Homeless population. Los Angeles County alone is home to an estimated 51,000 homeless individuals, with more than 62% of the population between 25-54 years of age.[2] Partnerships with agencies particularly serving this population, including local shelters, health centers, social services agencies and advocacy organizations will be crucial to ensuring that this Medi-Cal eligible population enrolls in and continues coverage.
- Populations with specific health conditions (e.g., sickle cell, HIV/AIDS, diabetes, childhood asthma). Because of their need for specific medical treatment, this population can take comfort in having access to health coverage and in no longer being denied coverage. The State could work with providers that address these illnesses to ensure their clients are linked to enrollment in either Medi-Cal or the Exchange.

Top Social Marketing & Outreach Activities (Question 3): The success of California's new coordinated healthcare system will in part depend on the investment in and design of the public information and social marketing campaign to educate individuals on new coverage options and changes to existing coverage options. As the State develops its social marketing plan, its first two activities must include the development of multiple partnerships and the implementation of a far-reaching media campaign. First, the State should identify and develop partnerships with entities that are trusted sources of information for families and communities. These partnerships will be helpful in getting the message out and distributing vital information to their networks. The State will need to work in coordination with these partners to create a unified message and set of materials that can be easily modified depending on the target audience. Second, the State will need to develop and implement a media plan that utilizes a wide range of traditional mass media and new marketing strategies. Public service announcements, static advertisements (e.g., billboards, posters), the use of ethnic mass media and social networking tools and connecting with recognized and trusted spokespersons should be included in that plan. Understanding the power of specific media strategies for different populations will be key to getting the word out and making sure that Californians are fully knowledgeable about how, why and where to access coverage.

A Successful Social Marketing & Outreach Campaign (Question 4): For the State's social marketing and outreach campaign to be a success, consumers should: (1) be fairly knowledgeable about what coverage options are available to them; (2) be aware of the basic benefits, requirements and protections they will

[1] State of California Employment Development Department. News Release. January 20, 2012.
[2] Los Angeles Homeless Services Agency. Greater Los Angeles Homeless Count. 2011.

receive; (3) understand the importance of coverage; (4) know how to enroll and where to go for assistance; and (5) feel assured of the program's reliability. To ensure this happens and help build consumer confidence in the Exchange, four important elements must be included in the campaign design:

1) A unifying brand and consistent messaging. The brand should covey that the program is reliable and is focused on the consumer. Messages should be clear and consistent as well as diminish any stigmas consumers have about publicly sponsored programs. Therefore messages should:
    - Not assume that the consumer knows what the ACA is or about its implementation in California. They should provide simple and easy information on how the consumer can enroll themselves and their families.
    - Avoid alienating certain populations such as undocumented populations. Families may be dissuaded from seeking coverage if not all family members are eligible so messages should be inclusive and promote a culture of coverage.
    - Promote key benefits that may attract a specific audience (e.g., for younger adults focusing on value for the money and access to preventative services).
    - Articulate business practices or policies that allow for simplified enrollment and seamless transitions between programs (i.e., automatic renewals, bridging between programs and multiple avenues of assistance). Knowing they can easily obtain and retain coverage provides consumers with a sense of security.
    - Establish a "culture of coverage" in which maintaining health insurance coverage becomes a norm for all children and families. There can be no stigma or perception of a "second tier" system. The public must see subsidized coverage through the Exchange as being equal in quality to coverage that is not subsidized and to employer-based coverage.

2) Cultural and linguistically relevant messages and imaging. Visual and verbal messaging must by culturally and linguistically relevant. This goes beyond translation and must include: sensitivity and use of culturally appropriate terminology, symbols, gestures and even color; the use and representation of a broad cross-section of the ethnic, racial, age, cultural, and socio-economic diversity of the population, business community and family structure.

3) Easy to understand materials and recognizable logo. Campaign materials and logos should be created that are culturally and linguistically appropriate. There should be a standardized "user-friendly" format for presenting coverage options that can be used by any agency, provider or community-based organization willing to assist with outreach activities. All consumer-related promotional and informational materials must meet the State's highest cultural, linguistic and language access (literacy level) standards. This should apply, but not be limited to, the dissemination and exchange of information via websites, toll-free telephone lines, media, required forms, and correspondence to the consumer. Materials should also be thoroughly vetted by consumers and other stakeholders prior to implementation. The State should also develop an easily recognizable 800 number that links to the call center.

4) Linkages with trustworthy entities. The State must develop partnerships with entities and utilize information channels that consumers are already familiar with and trust (e.g., local Elected Officials local safety-net providers, well known neighborhood advocates/activists, local media personalities, etc.). Partnerships with trusted people and agencies add legitimacy in the eyes of the consumer.

Additionally, it will be important that the social marketing and outreach campaign begins early in 2013. Consumers will need to be as familiar with the program as possible well in advance to make enrollment a smooth process. Furthermore, the campaign should be strong from 2014 through 2019 as consumers gain an understanding of the program and to convey any changes that occur during that time. A plan should be in place from the outset and data collected throughout the campaign to conduct real-time evaluation of its effectiveness, changes that need to be made and at what level the campaign should continue after 2019.

Sales, Outreach and Assistance Channels (Question 5) & Messengers (Question 15): Generally speaking, using various media outlets and working with local organizations and other trusted agencies will reach most individuals who will benefit from the Exchange and/or Medi-Cal Expansion. However, different populations will respond to different media outlets.

- The use of mass media outlets, including ethnic and language specific electronic and print advertisement and community programming, is the crucial element in reaching most market segments. According to a report by New American Media, in 2009 ethnic media reached 57 million or 87% of all African Americans, Hispanics and Asian Americans on a regular basis.[3] This was a 16% increase over 4 years prior. It will be critical for the state to identify those ethnic media channels and newspapers that resonate with different populations.

- Outreach channels should also include print advertisements in high traffic public places (e.g., malls, sports venues, personal care facilities, entertainment outlets). In thinking through the messages and appropriate spokespeople to be placed on advertisements, the state should identify public personalities who will appeal to multiple audiences or a few that can deliver the message to specific audiences.

- Social Media is a basic communication and information tool for a younger/tech savvy population. The development of smartphone and other online enrollment channels (including chat opportunities, access to online service reps, etc.) will be vital. Additionally, whereas ethnic and racial technology gaps still exist, more minorities are utilizing technology than ever before. Many (46% of African Americans and 51% of Hispanics) are accessing the internet on their cell phones.[4] The State will need to take this into consideration as it develops its social media strategies and messaging.

Promoting the spectrum of available coverage programs through the state and local public and private agencies and organizations (e.g., schools, WIC, DPSS ~ CalWorks/Food Stamps) that routinely interface with families and newly eligible adults increases the likelihood they will learn about the options available to them, utilize services and know where to go for assistance when needed. Partnerships with local agencies should include intact Certified Application Assistant, Promotora and Community Health Educator networks that have an established record in the segmented communities. Local faith-based agencies provide another channel to reach eligible individuals and families.

Print material should be readily available and disseminated through the communication vehicles of all state agencies such as the State Franchise Tax Board, Employment Development Department and through partnerships with the private sector. Partnerships with cities are of value in providing access to

[3] New American Media "2009 National Study on the Penetration of Ethnic Media in America" http://media.namx.org/polls/2009/06/Penetration_of_Ethnic_Media_Executive_Summary.pdf.
[4] Pew Research Center's Internet and American Life Project, April 29-May 30, 2010 Tracking Survey. Mobile Access 2010.

thousands of families and individuals through their mass transit systems (bus and rail), after-school programs, family resource centers, child care centers, parks and recreation programs, and public libraries, which are also well positioned as a resource for information dissemination. The marketing team should be responsible for developing relationships with major pharmacy chains, public utility companies (mobile phone, cable television, gas, electric, etc.) and other businesses within the private sector that have on-going communication tools and billing processes with the public.

Prioritized Groups (Questions 9): Although the State should create a social marketing plan that reaches as many California groups as possible, there are a few populations that should be prioritized to eliminate disparities in coverage. This includes the following populations and potential points of access:

- Uninsured but eligible children. To reach this population, use California's existing network of Certified Application Assistors (CAAs) and Outreach, Enrollment, Retention and Utilization (OERU) agencies because they are local, on-the-ground and able to reach families where they are (e.g., schools, clinics, WICs, Head-Starts, community and faith-based organizations). CAAs are seen as trusted entities and understand community norms, challenges and how to appropriately convey complex messages. Local CHIs (Children Health Initiatives) also work closely with CAAs and OERU agencies to coordinate local outreach and this expertise and connection should be utilized.

- Parents/caregivers of children in Medi-Cal and Healthy Families who are currently uninsured. Outreach to this population can be done via the child's health and/or mental health provider (e.g., nurses, counselors, and front-office staff). All health providers should be supplied and trained with information regarding enrollment in new and existing healthcare coverage options that they can share with parents and other family members. Schools will also be a main channel; statewide the California Department of Education should be involved in the creation of a mass media campaign across all county school districts. Understanding that children and their families have many needs and that the State comes in contact with a variety of organizations and agencies, the State should particularly work with local childcare providers and children-serving organizations (licensed day care, pre-school, Head Start, Boys and Girls Clubs, YMCA, AYSO, Little Leagues), public assistance agencies (WIC, Cal Fresh), and agencies that operate group homes or assist teens aging out of the foster care system.

- Low-income working childless adults. This population will need to be reached through a variety of methods. For those who access social or health services, local community/faith based organizations, community clinics (Federally Qualified Health Centers and private clinics) and government agencies (housing and employment departments) will be good avenues. For those who don't access local services, outreach will need to include mass media (TV, radio particularly for the low-literacy populations) and local community events and fairs. Messaging should be displayed and disseminated through partnerships with local supermarkets, pharmacies, public transit, and point of contact facilities that aren't traditionally part of the health information community (malls, beauty and nail salons, etc.).

Marketing Oversight Standards (Question 17): In an effort to avoid steering, marketing guidelines should be created for Qualified Health Plans that can be modeled from the Healthy Families Program. In addition to what is outlined in the "Healthy Families Participating Plan Marketing Guidelines," QHPs should not be allowed to hire or utilize volunteer enrollers. The Exchange Board should adopt the Healthy Families Monitoring, Oversight & Disciplinary Action Process with the change that coordination will be made with the Department of Insurance to report any violations and that consequences could

include loss of the plan's qualifying status. Additionally all Navigators and Agents/Brokers should adhere to similar outreach guidelines and be subject to monitoring to ensure that clients are not inappropriately steered to specific health plans.

Pre-Enrollment & Retention Coverage:

***Pre Enrollment Avenues (Question 10)*:** High-level coordination between the Exchange, Medi-Cal and Healthy Families and multiple public assistance agencies is necessary for automatic and seamless enrollment of eligible individuals and families into a healthcare coverage program. Public programs such as WIC, AIM and Family PACT are natural links because participants or other individuals in the family may become eligible for Medi-Cal or the Exchange due to their income. Other obvious links should be made with: the California Department of Education through local school lunch programs and child care programs, Utility Assistance Programs (e.g., CA Lifeline, Low-Income Home Energy Assistance Program) and Housing Assistance Programs; state unemployment as individuals move in and out of employment; the Department of Motor Vehicles. These state and local departments must work together to establish automatic healthcare coverage enrollment links via their existing electronic systems. Joint materials (brochures, introductory letters) between the State coverage programs and other public agencies would demonstrate the collaboration between agencies to the consumer and support for seamless enrollment. An effort should also be made to establish cooperative agreements with federally funded programs operating at the local level such as job and workforce development programs.

Hospitals also provide a great linkage to uninsured individuals who may be eligible for Medi-Cal or the Exchange. The State should coordinate with hospitals to link potential enrollees who seek emergency room services and either pay out-of-pocket or access the hospitals' charity services. Coordinating with the Department of Managed Health Care and Health Plans to obtain a list of COBRA enrollees is another avenue to identify potential beneficiaries. For example, the State could create a joint notice with health plans notifying their COBRA enrollees of their potential eligibility, provided that their information is still valid, and automatic enrollment into a coverage program.

Through the Healthy Families program, the State could generate a list of families who applied for but were rejected given their income level (over 250% FPL but less than 400%). The State could follow-up and notify these individuals of their potential eligibility in the Exchange and provide them with the opportunity to update their information and automatically enroll in the program or reject enrollment. Additionally, in order to participate in the Exchange, Qualified Health Plans should be required to share their list of individuals with existing insurance policies who have incomes below 400% FPL or the smallest amount of coverage (i.e., catastrophic). These individuals would have the opportunity to enroll in Medi-Cal or the Exchange with the option of remaining with their current health plan.

Additionally, to maximize enrollment prior to 2014, it is necessary for the State to provide funding opportunities and resources to various experienced OERU organizations to support specifically enrollment efforts (i.e., school and community-based outreach and enrollment "Navigator" contracts and grants). These "Navigator" contracts/grants can promote mandated outstationing of Navigator/CAA enrollers in nontraditional locations frequented by populations typically referred to as "hard-to-reach" (e.g., homeless shelters, mental health centers, churches). These locations can also be used to provide outreach materials targeting those individuals who will become newly eligible starting January 2014.

***Methods to Ensure Retention of Coverage (Question 11)*:** Retention of healthcare coverage is a cost-effective way to improve the continuity and quality of healthcare for children and families. Children and families often lose coverage at the time of annual renewal or when they fail to pay the monthly premiums required by some health insurance programs. In an effort to retain children and families currently enrolled in a health insurance program, the following retention strategies are recommended:

- Provide easy methods for paying premiums**.** Paying premiums should be made easy through the adoption of auto-pay programs with local banks and credit unions; payment by a wide range of credit and debit cards; online bill pay and payroll deduction; and payment via phone through the Exchange call center. In addition, for those who do not have access or choose not to use conventional banking, enrollees should have the option of paying at key locations within communities following the Healthy Families model of using pharmacies and bill payment centers.

- Provide affordable premiums and flexible payment plans**.** Implement a 3-month grace period for non-payment of premiums before coverage is dropped. Multiple attempts should be made to contact the individual for payment via several methods of communication (e.g., phone, mail, email).

- Assign retention specialists or navigators**.** Provide renewal assistance in the community at outstations with cultural and linguistic competency to walk individuals through new health benefits, navigate services, troubleshoot issues, retain coverage and educate consumers of his/her rights. Additionally, ensure that these Retention Specialists or Navigators do not have excessive caseloads that would preclude their meeting the needs of individual clients and their families.

- Create support systems for a "Passive Retention" approach**.** A *"Passive Retention"* approach works for the consumer by providing pre-populated renewal forms (i.e., only a signature is required if there are no changes to personal information affecting eligibility such as income) and electronic fund transfers from bank accounts to pay premiums so that action is not required on the part of the consumer to reenroll. Basically, if there are no changes, the consumer remains covered and does not need to take any action.

- Develop and utilize IT systems**.** Develop IT systems that will generate automatic alerts to consumers' emails and smart phones to trigger payment or renewal action to ensure continuity of care. The Navigator Program should be required to utilize social media as a way to assist families who have missed their renewal period when a successful phone or mail contact has not been made.

- Implement a Quality Improvement Plan. A *Quality Improvement Plan (QIP)* within the Exchange, Medi-Cal and Healthy Families will ensure attentive and appropriate customer service. By assessing the enrollment/retention system through feedback from consumers, Navigators and Agents/Brokers will assist with ongoing improvements and program integrity. Evaluation of progress on QIP should be reported at least twice a year or quarterly for the Exchange so that problems and gaps in services are acknowledged and remedied expediently.

Seamless transitions between the Exchange, Medi-Cal and Healthy Families (Question 14): Within Medi-Cal and Healthy Families, a bridging process is currently in place to move individuals and families from one program to the other when their eligibility changes during annual renewal. This bridging process should be extended to the Exchange and from the Exchange to Medi-Cal and Healthy Families. Medi-Cal and Healthy Families beneficiaries should be informed that their provider is in the QHP. If the provider is not in the QHP, they should be allowed to stay with them for a period of time to ensure

continuity of care. For individuals in the Exchange, the QHP should do its best to identify any changes in income or life situations that would make them eligible for Medi-Cal or Healthy Families before they are dropped for non-payment.

Consumer Education

***Enrollment in Non Health Service Programs (Question 47)*:** The enrollment IT system should be capable of making an automatic referral to other public assistance programs and vice versa. This should include technology that allows data used to determine eligibility in one program to prepopulate the application for services in other programs. This would expedite enrollment and reduce paperwork redundancy for the consumer. Although Navigators/CAAs/Enrollers will be well-trained in health coverage programs, it is not feasible to expect full knowledge in all public programs. Therefore, the Exchange must set up a comprehensive referral system to local resources by zip code so that consumers can locate assistance and services near their home, work, and school.

Functions of a Call Center (Question 53): Timely and effective enrollment into coverage hinges on the tools consumers have available to them to make informed decision about the benefits, health plans and providers that fit their personal needs and/or the needs of their families. Additionally, consumer assistance must go beyond outreach and enrollment and support retention of coverage and utilization of services to truly drive down costs, ensure access, and promote better health outcomes. An effectively designed and managed call center can provide access for those unable to use other communication vehicles. Therefore, the following functions are necessary for its overall success:

- 24 hour services or at a minimum extended service hours (e.g., 5am-11pm) for individuals who work traditional and non-traditional hours
- Ability to answer questions regarding the application process as well as status of an application
- Multi-language access or at the very least accommodate/respond to California's 11 threshold languages
- Respond to questions about the Exchange, Medi-Cal, and Healthy Families including policies and procedures, benefits, eligibility and QHPs
- Provide referrals to local resources and services (e.g., OERU agencies for additional follow-up, troubleshooting, public assistance agencies/services) based on the consumer's zip code
- Connect consumers to the Patient Advocate/Ombudsman to respond to consumer complaints, issues with QHPs, etc.
- Coordinate with all other major call centers or helplines statewide to provide local referrals for in-person assistance (e.g., health insurance/services and public assistance)
- Take payments or connect consumers to the payment center/department.

Call Center Performance/Successful Measures/Reports (Question 54): Several measurements are used to determine the efficiency and effectiveness of a call center. The following are critical components necessary for the call center to meet its goals and objectives and should be measured via a Quality Improvement Plan:

- Clear and transparent purpose, objectives and measurements
- Established standard, performance measures and benchmarks (call volume; hold times, call times; time before call is answered, etc.)

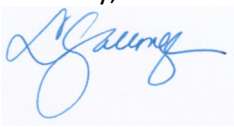
- Adequate call center workforce to field incoming calls (i.e., provide proper number of staff to handle calls during operating hours and more staff at specific hours of the day when the call volume is highest)
- Comprehensive, standardized, and ongoing staff training
- Infrastructure to manage and maintain call center technology system (phone lines, automatic transfers, etc.)
- Client satisfaction.

To measure these components, the following assessments should be made by an outside evaluation firm to ensure there is no conflict of interest:

- Staff and client surveys on challenges and successes immediately following the call
- Report the number of complaints received about the call center
- Navigator and referral agency feedback/input (via stakeholder process)
- Use of "secret shoppers" and evaluation of a sampling of calls across topics and languages to ensure consistent service and messages and appropriate referrals made
- Evaluation progress report on call center at 3 months, 6 months, and 12 months to make for ongoing adjustments/maintenance and management
- Evaluation report on operating hours and the percentage of incoming calls to determine the appropriate hours and staff required to meet demand and ensure resources are being used effectively and efficiently
- Transparency on all levels is shared with the public (progress report/performance measure results; consumer/advocate solicited feedback; next steps/recommendations for improvements, work plans and timelines).

We would like to thank the Health Benefits Exchange for giving us the opportunity to provide input on policies that will directly impact the lives of children, seniors, families and communities in California. We look forward to working with you to successfully implement the Affordable Care Act in our State and fully realize the vision of improving "the health of all Californians by assuring their access to affordable, high quality care." We hope that you will see our coalitions as a resource to help shape the direction and implementation of ACA and look forward to working with you. Should you require additional information or have any questions, please feel free to contact Sonya Vasquez, Policy Director, at 323.295.9372 extension 235.

Sincerely,



Lark Galloway-Gilliam, MPA
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