California HealthCare Foundation

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Issue Brief

Monitoring Performance: Locally Sponsored Versus Commercial Medi-Cal Plans

Introduction

Medi-Cal managed care has experienced major changes over the past five years. The program has expanded to reach new populations, provide more services, and operate in every county. Researchers looked at commercial versus locally-sponsored-Medi-Cal health plans to identify differences in performance.

This brief seeks to answer the following questions:

- Do large commercial plans, often with sizeable commercial and Medicare lines of business, parlay their scale and resources into better performance?
- Conversely, do locally sponsored plans leverage their local focus and community relationships into better performance?
- What factors might contribute to any differences that are found?

Background

The number of Medi-Cal beneficiaries enrolled in managed care has doubled in less than five years, from 3.6 million to 7.4 million between July 2009 and May 2014.[1] Several major program changes contributed to this enrollment surge: The number of participating counties grew from 27 to 30 in 2011, and then expanded to all 58 counties in 2013. The state began mandatory enrollment of seniors and persons with disabilities, a population with significant health care and long-term social support needs, in managed care in 2011.[2] Children enrolled in the Healthy Families program were transitioned to Medi-Cal managed care in 2013.[3] With implementation of the Affordable Care Act in 2014, the program was further expanded to include childless adults.

This transformation of Medi-Cal managed care has led to greater interest in, and oversight of, the performance of the program overall and of participating health plans. In 2013, the California Department of Health Care Services (DHCS) and the California HealthCare Foundation (CHCF) partnered with Navigant Consulting to create the first publicly available performance dashboard of the Medi-Cal managed care program. The dashboard tracks a set of indicators reflecting quality, access, consumer satisfaction, and financial performance.[4]

One set of comparisons possible with this dashboard is the performance of the three types of health plans with which DHCS contracts: commercial plans and two types of locally sponsored plans — County Organized Health Systems (COHS) and county-based Local Initiative plans (Appendix A). Interest in comparing plan type performance grew before Medi-Cal expanded managed care into the state's rural counties. Such interest also rises during debates over ways to reduce Medi-Cal spending or when the media report concerns about a health plan's quality rankings, financial health, or governance.

Methods

This research draws from data provided by DHCS to create the Medi-Cal managed care performance dashboard. The specific measures used in this study include the following:

- **Healthcare Effectiveness Data and Information Set (HEDIS) Composite for 2012.** The HEDIS composite summarizes health plan performance across 19 HEDIS measures reported by DHCS.[5] This methodology was developed by DHCS for its Health Plan Quality Awards. Higher scores are preferred.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Composite for 2010.** The CAHPS composite provides a summary of Medi-Cal enrollee satisfaction across eight adult and child CAHPS Global Ratings measures. It is a simple average of the percentage of members with responses of 8, 9, or 10 on a scale of 1–10 for each measure.[6] Higher scores are preferred.
- **All-Cause Readmission Rates for Seniors and People with Disabilities (SPD) for 2011.** This is the percentage of inpatient discharges for SPD members with a subsequent readmission within 30 days. Lower readmission rates, within reasonable parameters, are preferred.[7]
- **All-Cause Readmission Rates Among Non-SPDs for 2011.** This is the same measure as above but for Medi-Cal beneficiaries who are not elderly or disabled.[8]
- **Emergency Room (ER) Utilization Rates Among SPDs for 2012.** This is the number of ER visits per 1,000 member months.[9] Lower rates are generally preferred.[10]
- **Emergency Room Utilization Rates Among Non-SPDs for 2012.** This is the same measure as above, but for Medi-Cal beneficiaries who are neither elderly nor disabled.[11]

To supplement the data analysis, Navigant also conducted structured telephone interviews with people in five regions. In January and February 2014, Navigant conducted 20 individual and group telephone interviews with 49 stakeholders in two COHS counties, Monterey and Solano, and in three regions where a Local Initiative plan and a commercial plan compete (called "Two-Plan regions"), the Inland

Measure Considerations When Assessing Plan Performance

The performance measures were selected, in part, based on the availability of reliable data at the time of this study. Each measure has limitations that should be considered when assessing performance.

- **HEDIS and CAHPS.** HEDIS rates reflect health plan quality and a plan's ability to collect and report HEDIS data. Numerous factors outside of a plan's control may also affect HEDIS and CAHPS scores. For example, HEDIS measures are not risk adjusted, so plans with sicker or higher-risk members may be at a disadvantage compared to plans with healthier members. CAHPS responses are subjective, and there is some evidence that some graders are more critical than others.
- **All-Cause Readmission Rates.** Many readmissions are appropriate and may be for reasons unrelated to the initial admission. For example, a member who was initially admitted for a heart attack and later readmitted for an unrelated broken leg would count as a readmission. DHCS may want to consider reporting rates of potentially avoidable readmissions. Avoidable readmissions are those that arise due to a breakdown in the care continuum. They may be the result of patient behavior choices (such as noncompliance with prescribed therapies), medical error during the initial hospitalization, or lack of social supports, follow-up care, or understanding of discharge instructions.*
- **ER Utilization Rates.** The current ER Utilization Rate does not distinguish between appropriate and inappropriate ER visits. DHCS may want to consider reporting rates of potentially avoidable ER utilization or low-acuity, nonemergency (LANE) ER utilization. As with readmissions, potentially avoidable ER visits are those that arise due to a breakdown in the care continuum.

*Source: Jenny Minott, *Reducing Hospital Readmissions*, AcademyHealth, November 2008, www.academyhealth.org.

Empire (Riverside and San Bernardino Counties) and San Francisco and Tulare Counties. The five regions were selected to reflect geographic diversity, a mix of higher- and lower-performing health plans, at least one county without a public hospital, and multiple commercial plans.

The interviews explored several issues, such as:

- Key challenges faced by the Medi-Cal population in the county (not addressed in this paper)
- The contributions of the health plan to the community beyond providing health care services
- Collaboration among health plans and with providers and consumer groups
- Health plan activities considered to be promising or best practices

Interviewees are listed in Appendix B.

Study Limitations

The study has several important limitations:

- The depth and extent of the analysis were determined by the available data, which do not necessarily support the identification of causal relationships between observed performance and system, program, or plan characteristics.
- Available data reflect various time periods that precede the interviews by as much as five years.[12]
- Performance scores are a reflection of many factors in addition to health plan performance, such as county demographics, members' proximity to providers, access to convenient public transportation, and strength and capacity of the local health care delivery system.
- Although interviews were conducted with representatives of all seven health plans participating in the five regions, only nine other local stakeholders were interviewed for this study.
- Information provided during the interviews was self-reported and not independently validated. Interview findings are specific to the five counties in which interviews were conducted and may not be representative of other counties.

Analysis of Statewide Performance Measures

A straightforward comparison of average performance shows that performance does vary by plan type, but there is little consistency across the six measures (Table 1). COHS plans, on average, outperform county-based Local Initiative plans and commercial plans on both HEDIS and CAHPS composites as well as in ER utilization rates for SPD enrollees. However, COHS plans also have the highest average rates of all-cause readmissions for SPD and non-SPD populations and the highest ER utilization rates for non-SPD enrollees. With the exception of HEDIS and ER utilization rates for the SPD population, performance for county-based Local Initiatives and commercial plans is similar.

Table 1. Performance Average, by Plan Type

MEASURE	COUNTY-BASED LOCAL INITIATIVE	COMMERCIAL PLAN	COHS
HEDIS 2012 Composite (maximum possible score: 76)	45	35	52
CAHPS 2010 Composite	72%	73%	79%
All-Cause Readmissions — SPD (CY 2012)	15%	15%	16%
All-Cause Readmissions — Non-SPD (CY 2012)	10%	9%	11%
ER Utilization Rates* — SPD (CY 2012)	62	74	54
ER Utilization Rates* — Non-SPD (CY 2012)	38	38	41

*ER utilization rates reflect weighted averages and convey the number of ER visits per 1,000 member months.

Notes: For county-based Local Initiatives and commercial plans, straight averages were calculated for each measure except ER utilization. For COHS plans, straight averages were calculated for the HEDIS and CAHPS composite measures, and weighted averages were calculated for all-cause readmissions and ER utilization rates. For county-based Local Initiatives and commercial plans, all six measures reflect health plan performance in the following counties: Alameda, Contra Costa, Kern, Los Angeles, Riverside and San Bernardino (combined), San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. The CAHPS composite measure also includes data for Fresno County, and the ER utilization measures include data for Fresno, Kings, and Madera Counties.

Source: Navigant Consulting analysis of data provided by the California Department of Health Care Services (DHCS).

One approach to controlling for county-level factors is to limit the analysis to the Two-Plan counties where county-based Local Initiatives and commercial plans compete directly. Using this approach, county-based Local Initiatives and commercial plans perform similarly in four of the six measures (Table 2). On average, county-based Local Initiatives perform better than commercial plans on the HEDIS composite measure and on ER utilization for the SPD population.

Table 2. Performance Average, by Plan Type in Two-Plan Counties with Locally Sponsored Initiatives

MEASURE	COUNTY-BASED LOCAL INITIATIVE	COMMERCIAL PLAN
HEDIS 2012 Composite (maximum possible score: 76)	45	30
CAHPS 2010 Composite	72%	71%
All-Cause Readmissions — SPD (CY 2012)	15%	15%
All-Cause Readmissions — Non-SPD (CY 2012)	10%	9%
ER Utilization Rates* — SPD (CY 2012)	62	73
ER Utilization Rates* — Non-SPD (CY 2012)	38	37

*ER utilization rates reflect weighted averages and convey the number of ER visits per 1,000 member months.

Notes: Straight averages were calculated for each measure except ER utilization. All six measures reflect health plan performance in the following counties: Alameda, Contra Costa, Kern, Los Angeles, Riverside and San Bernardino (combined), San Francisco, San Joaquin, and Santa Clara. The CAHPS composite measure also includes data for Fresno County, and the ER utilization measures include data for Fresno, Kings, and Madera Counties.

Source: Navigant Consulting analysis of data provided by the California Department of Health Care Services (DHCS).

In head-to-head comparisons (that is, comparing the performance of just the two health plans operating in a county), more locally sponsored plans outperform their commercial plan counterparts on four of six measures (Table 3). While this may indicate that locally sponsored plans are generally outperforming their commercial plan counterparts, the head-to-head comparison does not take into account that the rates between the plan types may differ by only a few percentage points. For example, although six out of eight county-based Local Initiatives performed better on the CAHPS composite, the average absolute value difference between the higher- and lower-performing plan in a county was less than two percentage points.

Table 3. Comparison of Locally Sponsored and Commercial Health Plans in the Same County

	NUMBER OF COUNTIES WHERE...	
MEASURE	County-Based Local Initiative Performs Better	Commercial Plan Performs Better
HEDIS 2012 Composite	5	3
CAHPS 2010 Composite	6	2
All-Cause Readmissions — SPD (CY 2012)	2	6
All-Cause Readmissions — Non-SPD (CY 2012)	2	6
ER Utilization Rates — SPD (CY 2012)	8	3
ER Utilization Rates — Non-SPD (CY 2012)	9	2

Notes: All six measures reflect health plan performance in the following counties: Alameda, Contra Costa, Kern, Los Angeles, Riverside and San Bernardino (combined), San Francisco, San Joaquin, and Santa Clara. The CAHPS composite measure also includes data for Fresno County, and the ER utilization measures include data for Fresno, Kings, and Madera Counties.

Source: Navigant Consulting analysis of data provided by the California Department of Health Care Services (DHCS).

Plan Performance and Beneficiary Choice

County-based Local Initiatives and commercial plans appear to perform similarly with the exceptions of the HEDIS composite and of ER utilization for the SPD population. Yet, in every Two-Plan county with a county-based Local Initiative, more beneficiaries are enrolled in the Local Initiative than in the commercial plan. Overall, there are nearly three times as many Medi-Cal beneficiaries enrolled in locally sponsored plans as in commercial plans. Representatives of county-based Local Initiatives attributed their higher enrollment to stronger relationships with health care providers and with the community at large. Some of this enrollment difference can be attributed to the plan assignment algorithm DHCS uses with members who do not choose a plan themselves. The algorithm rewards health plans with higher HEDIS scores. Even among members who choose their health plan, however, most choose the county-based Local Initiative.

An analysis shows that the variation in performance within each plan type is greater than the variation in average performance across plan types (Table 4). For example, the HEDIS 2012 composite range between the commercial plan and COHS plan average is 17 points (35–52); however, the range within commercial plans is 54, and the range within COHS plans is 30. These results suggest that plan type may not be as meaningful as individual health plan approaches to health care delivery, demographics, and other county-specific factors.

Table 4. Performance Average and Ranges, by Plan Type

	COUNTY-BASED LOCAL INITIATIVE		COMMERCIAL PLANS		COHS	
MEASURE	Average	Min – Max	Average	Min – Max	Average	Min – Max
HEDIS 2012 Composite	45	27–73	35	15–69	52	38–68
CAHPS 2010 Composite	72%	69%–75%	73%	65%–85%	79%	78%–81%
All-Cause Readmissions — SPD (CY 2012)	15%	9%–20%	15%	10%–21%	16%	13%–19%
All-Cause Readmissions — Non-SPD (CY 2012)	10%	7%–12%	9%	5%–14%	11%	7%–13%
ER Utilization Rates* — SPD (CY 2012)	62	46–135	74	32–142	54	30–91
ER Utilization Rates* — Non-SPD (CY 2012)	38	16–59	38	20–63	41	25–57

*ER utilization rates reflect weighted averages and convey the number of ER visits per 1,000 member months.

Notes: For county-based Local Initiatives and commercial plans, straight averages were calculated for each measure except ER utilization. For COHS plans, straight averages were calculated for the HEDIS and CAHPS composite measures, and weighted averages were calculated for all-cause readmissions and ER utilization rates. For county-based Local Initiatives and commercial plans, all six measures reflect health plan performance in the following counties: Alameda, Contra Costa, Kern, Los Angeles, Riverside and San Bernardino (combined), San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. The CAHPS composite measure also includes data for Fresno County, and the ER utilization measures include data for Fresno, Kings, and Madera Counties.

Source: Navigant Consulting analysis of data provided by the California Department of Health Care Services (DHCS).

Lessons from Stakeholder Interviews

While the statewide performance measures DHCS reports are useful for understanding overall health plan performance, they do not provide a full picture of the value that health plans bring to Medi-Cal beneficiaries or to their communities. To understand these additional contributions, we interviewed stakeholders in five regions of the state: the Inland Empire (Riverside and San Bernardino Counties), and Monterey, San Francisco, Solano, and Tulare Counties.

Medi-Cal health plan representatives, consumer advocates, provider groups, and county officials interviewed for this study shared information regarding health plan initiatives, investments, and programs. Several common themes emerged from these interviews.

All Health Plans Invest in Their Communities, but Quantifying These Investments or Their Impact Is Difficult

Representatives of locally sponsored and commercial plans in the five regions indicated that their plans contribute to their communities in monetary and nonmonetary ways, including:

- **Paying for member and provider performance incentive programs.** All health plans reported one or more incentive programs with their providers. Examples include physician

pay-for-performance programs, hospital quality incentive programs, and targeted incentives to specialists to ensure timely access to care. All health plans also indicated they provide incentive programs for their members. Examples include gift cards, movie tickets, and raffle prizes for timely immunizations, maternity visits, and well-visits. Some plans emphasized the need for member and provider education on incentive programs to maximize program potential.

- **Purchasing medical and dental equipment for physician offices and clinics.** Some health plans indicated that they provided support for local provider practices by purchasing medical and other equipment, such as weight scales, adjustable examination tables, dental equipment, and vans, with the understanding that the equipment would benefit the community at large, not just the plan's own members.
- **Providing bridge funding for clinics during state budget crises.** One commercial plan reported that it offered interest-free loans to local clinics to keep facilities open and running during the California budget crisis from FY 2008–09 to FY 2012–13.
- **Sponsoring community health fairs and events.** All health plans indicated they sponsor or participate in numerous community events, many of which benefit residents other than a plan's members.
- **Supporting stakeholder advisory groups.** Many of the plans reported that their executives either support or are board members of stakeholder advisory groups, offering their insight and resources to help advance stakeholder causes. For example, one plan indicated its leadership conducts local forums to create opportunities for members and providers to connect and to discuss issues face-to-face.

The degree and method of participation in these types of activities and investments varied from county to county and from plan to plan. Consistent differences between locally sponsored and commercial plans were not evident from the interviews. In some counties, it appears that locally sponsored plans played a lead role in coordinating community forums, workgroups and outreach events; however, not every interviewee in every county supported this notion. In some instances, the commercial plan may have taken a lead on an initiative or in a community-based activity. One reason such investments may not manifest as differences in performance outcomes is that their benefits often extend beyond the plan's own members. Medical equipment purchases, for example, are likely to benefit a provider's entire patient panel, not just patients who belong to the plan that purchased the equipment.

Partnering with Providers

Three of the locally sponsored plans interviewed — San Francisco Health Plan, Central California Alliance for Health, and Partnership Health Plan of California — are partnering with external consultants to provide on-site training and consultation to providers to establish medical homes, improve transitions of care, and achieve better clinical outcomes. While it may be too early to see the results of this effort reflected in HEDIS performance, the implementation of these models may be indicative of the plans' general approach to partnering with providers and coordinating care. DHCS may consider monitoring the effectiveness of these models (and any others the plans may be undertaking) to measure impacts on selected HEDIS measures.

Health Plans Prefer Their Current Model

Representatives of each of the health plans interviewed prefer the model in which they currently operate. Locally sponsored and commercial plans in Two-Plan counties indicated that competition pushes them to improve their performance continuously and serves as a motivating factor in improving quality. COHS plans indicated that they are able to focus their resources on health care delivery (as opposed to other areas such as marketing) and that the COHS model facilitates continuity of care for members and reduces administrative complexity for providers. All of the plans we interviewed indicated a desire to keep their current plan models (i.e., COHS plans want to keep the COHS model, and Two-Plan county plans want to keep the Two-Plan model in their counties).

Plans Leverage Different Resources to Learn About Innovative Ideas, Best Practices, and Tools

Representatives of locally sponsored and commercial plans turn to colleagues in California and other states for ongoing learning opportunities. The approach of each plan type, however, differs. Representatives of locally sponsored plans indicated

that they draw extensively from the collective knowledge and experience of one another. CEOs and staff of locally sponsored plans frequently meet with and collaborate with peers through associations such as the Local Health Plans of California (LHPC) and the California Association of Health Insuring Organizations (CAHIO). By contrast, commercial plans operating in multiple states emphasized their ability to leverage the collective knowledge, experience, and resources of their national office and of sister plans operating in other states.

Commercial Plans Operating in Multiple States Offer Advantages and Disadvantages

Commercial plans that operate in multiple states may be better able to weather state-specific fiscal or economic challenges, such as when California has delayed paying health plans and providers for budgetary reasons. Operating in multiple states can also present challenges: When seeking resources and support for county-specific initiatives in California, commercial plans must typically present a business case to corporate leadership, which balances needs across all the markets in which the health plan operates.

Conclusion

There is no discernible difference in performance between locally sponsored or commercial health plans. Individual health plan performance and county-specific factors clearly affect performance scores. There is greater variation within plan types than there is between the locally sponsored and commercial plans competing within any particular county.

Currently, DHCS relies heavily on HEDIS measures to assess the quality of care provided by health plans. HEDIS is the only type of performance measure used in the DHCS quality awards and a major factor in the algorithm for automatically assigning beneficiaries who do not choose a plan themselves. The use of HEDIS is well founded: It represents nationally-accepted, standardized measures that allow DHCS to compare plan performance on select process and outcome measures. However, there are factors that affect health plan performance and contributions that plans make to their communities that are not necessarily reflected in HEDIS results. If DHCS values these other measures of performance, it should consider ways to systematically collect and report this information, and identify ways to recognize plans for these additional performance measures.

Monitoring performance is one element of a comprehensive program management and improvement strategy. Performance data should serve as a starting point for dialogue among state officials, health plan representatives, and other stakeholders to gather information on health plan initiatives, the effectiveness of those initiatives, barriers to success, and lessons learned. The ultimate goal of performance monitoring is to identify and spread initiatives that lead to improvements in the care and health status of Medi-Cal beneficiaries.

Appendix A: Medi-Cal Managed Care Enrollment, by Plan and Type, May 2014

Commercial Health Plans	
Anthem Blue Cross	539,830
California Health and Wellness	119,445
Care 1st	50,366
Community Health Group	180,809
Health Net	1,076,993
Kaiser Permanente	86,487
Molina Healthcare of California	308,617

Locally Sponsored Health Plans	
County Organized Health Systems	
CalOptima	576,172
CenCal	128,086
Central California Alliance for Health	253,517
Gold Coast Health Plan	148,287
Health Plan of San Mateo	115,472
Partnership Health Plan	418,914
Local Initiative Health Plans	
Alameda Alliance for Health	197,338
CalViva Health	248,747
Contra Costa Health Plan	118,354
Health Plan of San Joaquin	229,043
Inland Empire Health Plan	776,864
Kern Health Systems	152,309
L.A. Care Health Plan	1,385,691
San Francisco Health Plan	89,168
Santa Clara Family Health Plan	179,340

Note: Excludes specialty managed care plans: AIDS Healthcare Foundation (867 enrollees) and Family Mosaic (49 enrollees).
Source: California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports (May 2014), www.dhcs.ca.gov.

Appendix B: Interview Participants

Inland Empire
(Riverside and San Bernardino Counties)

Inland Empire Health Plan
Bradley Gilbert, William Henning, Kurt Hubler, Jeanna Kendrick

Kids Come First Community Health Center
Beverly Speak

Molina Healthcare of California
Ruthy Argumedo, Joy Bland, Richard Chambers, James Cruz, Kim Yunkyung

Monterey County

Central California Alliance for Health
Dale Bishop, Alan McKay, Rachael Nava

Monterey County Board of Supervisors
Wendy Askew, Jane Parker

San Francisco County

Anthem Blue Cross
Andrew Gomes, Barsam Kasravi, Steve Melody, Sallie Negin, Janet Paine, Daniel Shydler, Gloria Thornton

NICOS Chinese Health Coalition
Kent Woo

San Francisco Health Plan
John Grgurina, Deena Louie, Nina Maruyama, Kelly Pfeifer

Solano County

Legal Services of Northern California
Leon Dixon

Partnership Health Plan
Liz Gibboney, Jack Horn, Mary Kerlin, Robert Layne, Robert Moore, Debbie Shafer

Tulare County

Anthem Blue Cross
Andrew Gomes, Barsam Kasravi, Steve Melody, Sallie Negin, Janet Paine, Daniel Shydler

Central California Legal Services
Michael Brooks

First 5 Tulare County
Janet Hogan

Fresno Healthy Communities Access Partners
Norma Forbes

Health Net
Andrea Broughton, Armando Cabrera, David Friedman, James Gerson, Peggy Haines, Tom Hamilton, Carol Kim, Elaine Robinson, Anthony Van Goor

Tulare Community Health Clinic
Graciela Soto

Tulare County Department of Public Health
Jason Britt, Karen Elliot

About Navigant

Navigant Healthcare takes a unique interdisciplinary approach to our clients' challenges. This means we work as one team with one goal, leveraging the strengths and expertise of our senior-level consulting professionals in the delivery of integrated solutions. With the depth and breadth of our industry experience as health care executives, clinicians, and physicians, we enable clients to build their capabilities and achieve sustainable peak performance around quality of care, cost, leadership, and culture in today's changing health care environment.

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About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

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Endnotes

1. California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports, available at www.dhcs.ca.gov.
2. Ibid.
3. California Department of Health Care Services, Medi-Cal Managed Care Expansion available at www.dhcs.ca.gov and Healthy Families Transition to Medi-Cal, available at www.dhcs.ca.gov.
4. Versions of Medi-Cal managed care dashboard are available at www.chcf.org and www.dhcs.ca.gov.
5. See www.chcf.org for more detailed information about the HEDIS composite measure.
6. The *Medi-Cal Managed Care Program 2010 CAHPS Summary Report* reports responses of 9 or 10 on a scale of 1–10. The project advisory group recommended that including responses of 8 would result in a better reflection of satisfied health plan members.
7. Rates provided by DHCS.
8. Ibid.
9. A member month is one person enrolled for one month. A person enrolled for one year is 12 member months.
10. Rates provided by DHCS.
11. Ibid.
12. When this study was conducted, the most recent CAHPS data available were from calendar year 2009.