Medi-Cal Managed Care Division

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Medi-Cal Managed Care External Quality Review Organization

2007-2008 Annual Report of Performance for Family Mosaic Project

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DHCS
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Delmarva Foundation
Improving Health in the Communities We Serve

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Introduction

As of 2009, the Medi-Cal Managed Care Division (MMCD) of the California Department of Health Care Services (the DHCS or "the Department") contracts with health care plans to provide care to 3.6 million Medi-Cal beneficiaries enrolled in managed care plans in 25 counties throughout California. Healthcare providers within each plan's contracted network provide comprehensive healthcare services—primary and preventive care, as well as the full range of specialty care mandated by federal and state law.

Federal law pertaining to Medicaid managed care programs (42 CFR § 438.240) requires the DHCS to contract with an External Quality Review Organization (EQRO) to independently evaluate the quality of care provided to Medi-Cal beneficiaries enrolled in any of California's managed care plans. During the period covered by this report, the DHCS retained the services of the Delmarva Foundation for Medical Care (Delmarva) as its EQRO. Among the services provided by the EQRO is an annual independent assessment of each contracted plan's "… quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract…" as stated in Title 42 of the U.S. Code.

Plan Background

Most Medi-Cal beneficiaries enrolled in managed care plans receive their health care through full-scope Managed Care Organizations (MCOs), most of which are licensed Health Maintenance Organizations (HMOs). Most Medi-Cal beneficiaries enrolled in managed care plans receive their health care through three models of health care delivery[1]. DHCS also contracts with a few "specialty plans."

Specialty health plans are differ from regular health plans in that they serve a special group of the Medi-Cal population. Family Mosaic Project (FMP or "the plan") began contracting with the State of California as a Medi-Cal managed care specialty plan in 1993. Originally a pilot project of the Robert Wood Johnson

[1] Medi-Cal managed care's three models of health care delivery: County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Two-Plan. COHS plans are county-operated managed care organizations. In the GMC model, enrollees choose from several commercially operated plans within a certain geographic area. The Two-Plan model consists of Commercial Plans (CPs)—which are commercially operated managed care plans—and Local Initiatives (LIs)—which are community-developed managed care plans that operate as quasi-governmental agencies.

Foundation, FMP is currently part of the Child, Youth & Family System of Care System operated by the City and County of San Francisco's Department of Public Health, Community Behavioral Health Services. FMP provides intensive care management and wraparound services to Medi-Cal's seriously emotionally disturbed children and youth, who are at risk for out-of-home placement.

Enrollment criteria for FMP clients are that the member must be (1) a San Francisco resident between the ages of 3 and 18, (2) seriously emotionally troubled, and (3) at imminent risk of out-of-home placement or already in an out-of-home placement. Under its contract with the DHCS, FMP's program receives a per-member, per-month capitated rate to provide mental health and related services to its Medi-Cal members. As a condition of the contract, the County's Community Behavioral Health Services is at risk for all psychiatric inpatient costs for enrolled members. As of December 2007, FMP reported that it served 103 Medi-Cal enrollees.

Federal Reporting Requirements

In 2006, the Centers for Medicare and Medicaid Services (CMS) directed the DHCS to make specialty plans subject to the same external quality review requirements as other Medi-Cal managed care plans. Federal regulations require that the quality of care—including access and timeliness—be evaluated annually by an EQRO. Due to the small size of specialty plan populations, the DHCS modified the external quality review requirements applied to these plans as follows:

- Instead of the twelve Healthcare Effectiveness Data and Information Set (HEDIS®)[2] performance measures required of regular plans, the DHCS requires specialty plans to report on only two performance measures (HEDIS or other), selected to be appropriate to the plan's population. Plans must report performance measurement results that are specific to the plan's Medi-Cal managed care members and not the plan's entire population.

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA, 2008). HEDIS is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS measures are used by health care purchasers to assess the quality, access, and timeliness of care and service provided to members of managed care plans. For a more detailed explanation of HEDIS, see Appendix: HEDIS.

- Specialty plans are not required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] surveys, but instead are required to conduct some kind of plan-developed member satisfaction survey and periodically report results to the DHCS and the EQRO.
- While specialty plans must be engaged in two Quality Improvement Projects (QIPs) at all times just as regular plans, specialty plans are not required to participate in statewide collaborative QIPs.

The Department amended FMP's contract effective January 1, 2008, to add requirements that the plan must (1) report on two performance measures annually, (2) maintain two internal QIPs, and (3) submit to the DHCS the results of a consumer satisfaction survey conducted by the FMP. This is MMCD's first annual review for FMP and covers reporting years 2007 and 2008, focusing on the development of performance measurements and quality improvement activities that will comply with Federal and State reporting requirements, as well as the results of any quality improvement activities conducted during calendar years 2006 and 2007.

The following review and evaluation of plan performance is brief, in part, due to delays in the development and approval of FMP's revised contract requirements, which resulted in postponement of the planned monitoring activities. During the period covered by this report, the plan was in the early stages of implementing required activities.

Data for the specialty plans is frequently limited due to the uniqueness of the population served and the small population size. Benchmarks to measure FMP's performance against are limited due to the plans' specialized population. Because information was not available for all data sources, Delmarva could not provide a complete assessment.

After Delmarva's EQRO contract with the DHCS expired in June 2008, another EQRO began working with FMP to determine available data sources to support development of performance measures and QIPs. Those activities will be reflected in the next annual performance review. The next annual performance review should present a more complete assessment.

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[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ, 2008). The CAHPS program is funded and administered by the U.S. Agency of Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private organizations to develop and support a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their health care experiences. AHRQ developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2007 4.0H Adult Medicaid and the 3.0H Child Medicaid surveys. Delmarva conducted these CAPHS surveys in 2007 for MMCD's regular contracted health care plans.

Definitions

Federal and State regulations require that contracted Medi-Cal plans be assessed for the standards quality, access, and timeliness. The terms quality, access, and timeliness provide the framework for this plan-specific review of FMP. Consistency in meaning and use of these key terms are important for a thorough understanding of this report, so definitions are provided below:

- **Quality**, as it pertains to external quality review, is defined by the Centers for Medicare & Medicaid Service (CMS) as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." (CMS, 2008)
- **Access** (or accessibility) to health care, according to the Agency for Healthcare Research and Quality (AHRQ), means having "the timely use of personal health services to achieve the best health outcomes. Attaining good access to care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services; and, finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust." (AHRQ, 2007)
- **Timeliness,** according to AHRQ, is defined as "…the health care system's capacity to provide health care quickly after a need is recognized….Measures of timeliness include waiting time spent in doctors' offices and emergency departments (EDs) and the interval between identifying a need for specific tests and treatments and actually receiving those services." (AHRQ, 2007)

Data Sources Used to Assess Family Mosaic Project

Delmarva typically uses types of standards or information sources to assess Medi-Cal managed care plans performance relative to a plan's ability to provide its members with care that meets Federal and State quality, access, and timeliness requirements. Because FMP's contract requirements changed during the period covered by this report, data sources available for Delmarva's assessment were limited.

- **Performance Measures.** Although much dialogue occurred among FMP, Delmarva, and the DHCS around external quality review requirement, FMP's contract with the DHCS did not specify a requirement to report performance measures in its contract with the DHCS until January 1, 2008. Due to delays in the development and approval of new contract requirements, FMP had not yet selected two measures to fulfill DHCS's performance measure reporting requirement for reporting year 2008 (for measurement year 2007); therefore, no performance measurement results are included in this report. MMCD indicates that non-HEDIS performance measures have since been developed for FMP, and results will be included for the first time in the 2010 HEDIS report.

- **Member Satisfaction Surveys.** FMP's contract with the DHCS did not specify a requirement to conduct an annual consumer satisfaction survey and annually submits results to the Department until January 1, 2008. The contract requires the survey to address the population served and measure consumer satisfaction with respect to perceived accessibility of services, adequacy of care and services, continuity of care, coordination of services, and health education. This report summarizes discussions and development of FMP's plan-designed member satisfaction surveys during 2007 and 2008.
- **Quality Improvement Projects.** FMP's contract with the DHCS did not specify a requirement to conduct Quality Improvement Projects (QIPs) until January 1, 2008. FMP's current contract specifies that the plan is required to conduct two QIPs approved by DHCS. This report summarizes discussions and development of FMP's quality improvement projects during 2007 and 2008.
- **Medi-Cal Medical Audits.** The DHCS's Audits and Investigations Division and the California Department of Managed Health Care (DMHC) conduct routine medical surveys (audits) to assess plan compliance with contract requirements and state regulations for MMCD's regular plans. However, because FMP is a specialty plan operating as a Community Behavior Health Services program under San Francisco's Department of Public Health, it is instead audited by the California Department of Mental Health (DMH). FMP was scheduled to have an Early and Periodic Screening, Diagnosis and Treatment chart review audit conducted by the DMH in February 2008. However, DMH does not provide the results of its audits to DHCS, so this report contains no assessment of the plan's medical audit.
- **Grievance and Appeal Data**. Medi-Cal managed care plans must comply with federal requirements regarding maintenance of a grievance system. While most of Medi-Cal managed care plans are required to submit quarterly grievance and appeal data reports to MMCD, FMP's contract does not require the plan to submit these reports. MMCD's Office of the Ombudsman does prepare reports summarizing member calls received by the Office of the Ombudsman for contracted plans, including any calls from FMP members.

Quality Improvement Performance Measures

While specialty plans are not required to report on the same measures as regular Medi-Cal managed care plans, these plans are required to report annual results for two performance measures, chosen in collaboration between the DHCS, the EQRO, and the plan. The measures are selected or developed to be relevant the plan's membership.

In 2006, Delmarva provided the DHCS with a list of potential performance measures relevant to FMP's member population to assist the DHCS and FMP with the selection of two measures. In order to reduce the time and financial expense of a medical record review for the plan, Delmarva recommended numerous

measures that used administrative data to access the plan's performance in areas timeliness, quality, and access:

- **Timeliness**
  - Post-hospitalization referrals.
  - Medication reviews.
- **Quality**
  - Communications with primary care practitioners.
  - Inpatient facility readmissions.
  - Improvement of functional living.
  - Members staying in home setting.
  - Admissions to behavioral health facilities.
- **Access**
  - Preventive health visits.
  - HEDIS measures regarding mental health utilization.

By 2007, the DHCS and FMP had not yet selected performance measures. At that time, Delmarva recommended the plan report two of the following three measures for which there appeared to be adequate internal data:

- Appropriate change in the Child and Adolescent Functional Assessment Scale (CAFAS) risk score between intake and most recent measurement.
- The percent of members whose files include a case management plan.
- The percent of members receiving initial contact from FMP within 48 hours of enrollment.

In late 2007, FMP proposed other possible performance measures, but these were not selected by the time Delmarva's DHCS contract expired in June 2008. At that point, the new EQRO began working with the plan to finalize selection of performance measures, which DHCS indicates was completed in mid-2009. The next performance review will report on subsequent activities in this area.

Quality Improvement Projects

Specialty plans are required to participate in two Quality Improvement Projects (QIPs) at all times, but are not required to participate in the statewide collaborative QIP. Specialty plans may conduct either two internal QIPs or conduct one internal QIP and participate in a small group collaborative QIP if approved by the DHCS.

In early 2008, FMP submitted a potential QIP topic entitled "The Incredible Years." *The Incredible Years* problem statement indicated that approximately half of preschool children receiving publicly funded childcare services in San Francisco evidenced early symptoms of externalizing disorders (referred to by parents as "acting out"). Many of these children did not receive timely evidence-based services to address these behaviors, placing them at risk for later academic, social, and behavioral problems. FMP sought to determine if implementation of a parenting program (*The Incredible Years*) would reduce disruptive behaviors and improve social competence in preschool age children who were currently exhibiting disruptive behaviors at home, in preschool, or in childcare settings.

The Incredible Years project was reviewed by both the DHCS and Delmarva, and it was determined that the plan could move forward with the project as a QIP. FMP submitted a formal QIP proposal for this project in early 2008, but the proposal was not finalized or validated by the time Delmarva's contract with the DHCS expired in June 2008. Therefore, the next EQRO took over working with FMP to develop acceptable QIP proposals. The status of that work will be included in the next performance review.

Member Satisfaction Survey

In 2006, FMP administered a Youth Services Survey that included 21 questions related to satisfaction and services received. The plan received 100 valid survey responses with scores that ranged from 3.9 to 4.6 on a 5-point scale for each of the 21 questions surveyed. Items were scored from 1 (strongly disagree) to 5 (strongly agree). The table below presents results for five of the 21 items surveyed:

Table 1. Family Mosaic Project 2006 Youth Services Survey.

2006 Youth Services Survey Item	FMP's Mean Score*
Overall, I am satisfied with the services I received.	4.5
I received services that were right for me.	4.4
I got the help I wanted.	4.4
I am better at handling daily life.	4.0
I am satisfied with my family life right now.	3.9
* Each mean score was based on 1 to 5 rating: 1 = strongly disagree; 5 = strongly agree.	

In 2007, FMP again administered a Youth Services Survey that included 22 questions related to satisfaction and services received. Although Delmarva did not validate the survey results, the plan reported that it received 57 valid survey responses with mean scores that ranged from 3.7 to 4.6 on a 5-point scale for each of

the 22 questions surveyed. Items were scored from 1 (strongly disagree) to 5 (strongly agree). The table below presents results for the same five items (out of 22):

Table 2. Family Mosaic Project 2007 Youth Services Survey.

2007 Youth Services Survey Item	FMP's Mean Score*
Overall, I am satisfied with the services I received.	4.0
I received services that were right for me.	4.3
I got the help I wanted.	4.3
I am better at handling daily life.	3.9
I am satisfied with my family life right now.	3.7
* Each mean score was based on 1 to 5 rating: 1 = strongly disagree; 5 = strongly agree.	

The score for each surveyed item was lower in the 2008 survey than the 2007 survey, and the number of valid surveys received by FMP was much lower in 2008 than 2007 (57 versus 100, respectively). This report can draw no conclusions because the number of surveys was low and Delmarva did not validate the survey results. This report presents survey results for informational purposes only.

Grievance and Ombudsman Reports

MMCD requires plans contracted with the DHCS to maintain grievance systems in accordance with the California Code of Regulations, Title 28, Section 1300.68. Plans must track all written and verbal grievances received in a grievance log. While the DHCS requires most of its plans to submit detailed grievance and appeal data reports to MMCD each quarter, FMP's contract does not require it to submit quarterly grievance and appeal data reports to MMCD. FMP is required to maintain a grievance log and the log is reviewed by DHCS's Member Rights/Program Integrity team during its on-site reviews.

MMCD's Office of the Ombudsman provides assistance to members who have questions or problems related to provider and plan services, as well as other areas, such as Medi-Cal eligibility. The Office of the Ombudsman functions, in part, to help solve problems from a neutral standpoint to ensure that members receive all medically necessary covered services for which plans are contractually responsible. Complaints or issues that are not resolved immediately by the Office of the Ombudsman are entered into the Ombudsman Case Management System (OCMS) for tracking and follow-up. The Office of the Ombudsman also assists members who wish to request a formal hearing with the State Fair Hearings Board.

It should be noted that the DHCS monitors plans' quarterly grievance reports and MMCD Office of the Ombudsman monthly statistics in order to understand what aspects of provider and plan performance generate many or few grievances, calls, or requests for State Fair Hearings over time. The Department holds discussions with plans regarding unusual patterns in grievances, calls, or hearing requests when appropriate. The Department does not generally perceive any particular number of grievances, calls, or hearing requests as indicators of poor plan performance. Rather, these statistics are an ongoing indication of the degree to which plan members are using the various avenues available to them to ask questions or raise concerns about healthcare quality and plan service.

Family Mosaic Project's Grievance Reports

During 2008, DHCS's Member Rights/Program Integrity Unit held an on-site Member Rights Monitoring Review. Several elements of the plan's grievance process were addressed during the 2008 Member Rights Monitoring Review. Reviewers noted that FMP had recorded four member grievances during the two-year period prior to the review. Three of the grievances were administrative in nature, and one pertained to quality of care.

Office of the Ombudsman's Reports

The Office of the Ombudsman reported no calls, cases or State Fair Hearings requests from Family Mosaic members for 2006 and 2007. Due to the unique services provided by FMP, it is unlikely that the plan's members would use the services of MMCD's Ombudsman. Members would more likely seek assistance directly from their FMP caseworker, their county eligibility worker, or perhaps the City and County of San Francisco's Department of Public Health.

Conclusions

This is the first annual review for the specialty plan, and it should be noted that FMP's contract was revised effective January 1, 2008, and the terms of the new contract included more specific language about quality performance requirements. The timing of the contract update contributed to some of the plan's delays in achieving full compliance with regard to quality performance. The plan is continuing to implement quality improvement initiatives to align with Department requirements.

Beginning in 2006 and during the period covered by the report, Delmarva worked with FMP and the DHCS to select relevant performance measures for the plan, but that process had not yet been completed. At the time this report was written, the new EQRO began working with the plan to finalize selection of performance measures, which DHCS indicates was completed in mid-2009. The next performance review will report on subsequent activities in this area.

The plan submitted a formal proposal for *The Incredible Years* QIP in early 2008, but the proposal was not finalized or validated by the time Delmarva's contract with the DHCS expired in June 2008. Therefore, the next EQRO took over working with FMP to develop acceptable QIP proposals. The status of that work will be included in the next performance review.

In 2006, FMP administered a Youth Services Survey related to satisfaction of services received and collected 100 valid survey responses. Results appeared to be favorable and ranged from 3.9 to 4.6 on a 5-point scale. In 2007, FMP again administered a Youth Services Survey. Results appeared to be slightly less positive than the previous year and ranged from 3.7 to 4.6 on a 5-point scale. No conclusions can be drawn from the results due to the low number of surveys collected and because Delmarva did not validate the 2008 survey results.

The Office of the Ombudsman reported no calls, cases, or State Fair Hearings requests from FMP members for 2006 and 2007, most likely because of the unique services provided by FMP and that plan members are more likely to seek assistance directly from more local resources.

Recommendations

DHCS is obligated to ensure that each plan is compliant with contract requirements related to quality of care to provide technical assistance to the plan regarding quality improvement initiatives. Annual reporting of performance measures, QIPs, and administration of a member satisfaction survey are required by all plans. FMP must work collaboratively with DHCS and the EQRO to become more fully compliant with federal and State standards. Delmarva specifically recommends that:

- FMP isolate data and results for its Medi-Cal managed care members to support a performance improvement program that targets this population.
- FMP select two performance measures to report and report annual results.
- FMP implement two QIPs and report annually on their status.
- FMP continue to report annually the results of the plan's member satisfaction survey.

It should be noted that subsequent to the period covered by this report, FMP made substantive progress related to the above recommendations. These developments will be discussed and evaluated in the next annual report.

Appendix: HEDIS®

HEDIS Background

The Healthcare Effectiveness Data and Information Set (HEDIS®)[4] is a nationally recognized, standardized set of performance indicators developed by the National Committee for Quality Assurance (NCQA). NCQA's Committee on Performance Measurement annually evaluates and makes collective decisions about the content of the measures and the entire HEDIS process. State governments, employer and business groups, payers, and consumers use the results of these measures. More than 90 percent of all national health plans use HEDIS to measure their performance on established dimensions of health care and plan services.

HEDIS data collection and validation is standardized across all plans. HEDIS methodology makes it possible to compare the performance of health plans to each other and to national benchmarks. Results are used to identify performance variances to help plans focus their quality improvement activities.

HEDIS Domains of Care

NCQA assigns each of the technically-defined HEDIS measures (71 measures in 2007 and 70 measures in 2008) to one of eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care (Adult and Child CAHPS)
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Health Care Choices

DHCS-Required Measures

2007 DHCS-Required HEDIS Measures

For the 2007 reporting year (2006 measurement year), the DHCS required its regular contracted plans to report on 12 selected HEDIS measures—including multiple indicators for *Comprehensive Diabetes Care* and

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Prenatal and Postpartum Care—for a total of 16 measurement indicators.[5] Because Family Mosaic Project is a specialty plan, MMCD did not require the plan to report on any of these 16 indicators. Instead, DHCS specified that each specialty plan would report two performance measures (HEDIS or other), selected as appropriate to the plan's members and approved by MMCD. Although Family Mosaic's contract did not specify reporting of performance measures until January 1, 2008, during 2007 Delmarva offered suggestions to the plan regarding possible performance measures.

2008 DHCS-Required HEDIS Measures

For the 2008 reporting year (2007 measurement year), the DHCS required its regular contacted plans to report on 12 selected HEDIS measures— including multiple indicators for *Ambulatory Care*, *Childhood Immunization Status*, *Comprehensive Diabetes Care,* and *Prenatal and Postpartum Care*—for a total of 23 measurement indicators.[6] For the 2008 Reporting Year, the DHCS required its regular contacted plans to report on 12 selected HEDIS measures— including multiple indicators for *Ambulatory Care*, *Childhood Immunization Status*, *Comprehensive Diabetes Care,* and *Prenatal and Postpartum Care*—for a total of 23 measurement indicators. Again, as a specialty plan, MMCD exempted FMP from the HEDIS reporting requirements of regular plans; instead, Delmarva continued working with FMP on the selection of two appropriate performance measures. However, this selection had not been finalized before the expiration of Delmarva's DHCS contract in June 2008.

The DHCS strives to select measures that gauge the quality of care provided to and access to care experienced by the largest segments of the Medi-Cal managed care population. The EQRO compiles and validates the measurement results from all the plans and communicates the results to the DHCS in an annual *Performance Measures for Medi-Cal Managed Care Plans* report.

The *Report of the 2007 Performance Measures for Medi-Cal Managed Care Plans* and the *Report of the 2008 Performance Measures for Medi-Cal Managed Care Plans* ("*Annual Performance Measures reports*") provide the Medi-Cal managed care weighted average for each measure. The Medi-Cal managed care weighted average accounts for variation in membership across plans. The plans' HEDIS data processes are audited according to the protocols described in the *Annual Performance Measures reports.* No performance measure rates for FMP were included in the 2007 and 2008 *Performance Measures reports.*

[5] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 06-010, entitled "Quality and Performance Improvement Program Requirements for 2007."

[6] The measures are set forth annually in All Plan Letters issued by the DHCS and available on its website. See All Plan Letter No. 07-013, entitled "Quality and Performance Improvement Program Requirements for 2008."

Performance Level Criteria

The *Annual Performance Measures reports* utilize the following established benchmarks in assessing plans' performance on measures:

- Medi-Cal Managed Care Weighted Average (Same Year)
- National Medicaid Average (Prior Year)
- National Commercial Average (Prior Year)

The DHCS compares plan rates to Minimum Performance Levels (MPLs) and High Performance Levels (HPLs) for each measure to assess further program-wide quality of care and to identify specific health plan improvement needs. MPLs and HPLs are equal to the 25th and the 90th percentiles, respectively, of the 2006 and 2007 national Medicaid results. The performance benchmarks (MPLs and HPLs) were taken from NCQA's *Quality Compass* for the previous year.

The HPL rates help identify plans that outperform the national Medicaid 90th percentile from the previous year. The DHCS does not apply the MPL and HPL to the first-year scores reported for any measure since that rate establishes a "baseline". Similarly, the MPL and HPL are not applied in years when there were substantive changes to a measure's technical specifications, since making a comparison to the previous rate would be inappropriate.

It should be noted that FMP's performance measures will be included in the 2009 *Performance Measures report* and scores will be reported for the first time in the 2010 *Performance Measures report*.

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