AETNA BETTER HEALTH OF LOUISIANA

Annual External Quality Review Technical Report

Review Period: July 1, 2015 – June 30, 2016
April 2017

Prepared on Behalf of
The State of Louisiana
Department of Health & Hospitals

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I. INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in 42 Code of Federal Regulations (CFR) 438.320 as *"the degree to which an MCO or 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"*.

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Bayou Health Program, and each of the participating Health Plans on the accessibility, timeliness and quality of services. Specifically, this report provides IPRO's independent evaluation of the services provided by Aetna Better Health of Louisiana (Aetna) for review period July 1, 2015 – June 30, 2016.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as Louisiana State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA's *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Section VI provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by IPRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

II. MCO CORPORATE PROFILE

Table 1: Corporate Profile

Aetna	
Type of Organization	Health Maintenance Organization (HMO)
Tax Status	For Profit
Year Operational	2015
Product Line(s)	Medicaid and LaCHIP
Total Medicaid Enrollment (as of June 2016)	89,575

III. ENROLLMENT AND PROVIDER NETWORK

Enrollment

Medicaid Enrollment

As of June 2016, the Health Plan's Medicaid enrollment totaled 89,575, which represents 7% of Bayou Health's active members. Table 2 displays Aetna's Medicaid enrollment for 2015 to 2016, as well as the statewide enrollment total. Figure 1 displays Bayou Health's membership distribution across all Health Plans.

Table 2: Medicaid Enrollment as of June 2016[1]

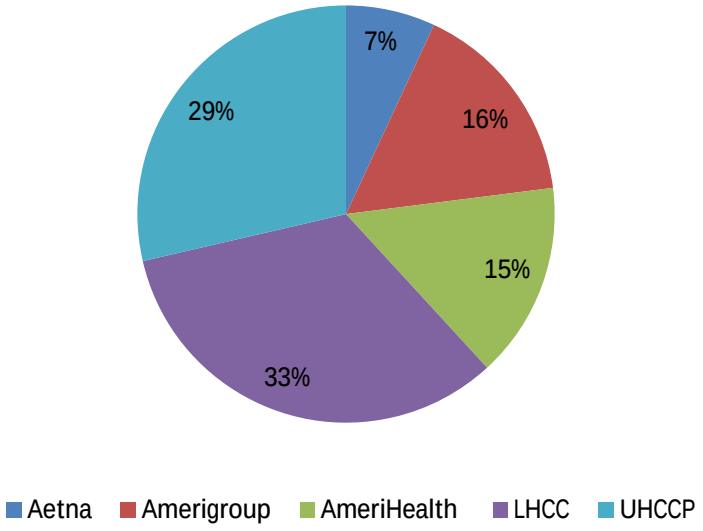
Aetna	June 2015	June 2016	% Change	June 2016 Statewide Total[2]
Total Enrollment	26,100	89,575	110%	1,292,032

Data Source: Report No. 125-A

[1] This report shows all active members in Bayou Health as of the effective date above. Members who will be disenrolled at the end of the reporting month are not included. Enrollees who gain and lose eligibility during the reporting month are not included. Enrollees who opt out of Bayou Health during the reporting month are not included.

[2] Note: The statewide total includes membership of all plans.

Figure 1. Bayou Health Membership by Health Plan as of June 2016



Provider Network

Providers by Specialty

The LDH requires each MCO to report on a quarterly basis the total number of network providers. Table 3 shows the sum of Aetna's primary care providers, OB/GYNs and other physicians with primary care responsibilities within each geographic service area as of June 30, 2016.

Table 3: Primary Care & OB/GYN Counts by Geographic Service Area (GSA)

Specialty	Aetna			MCO Statewide Unduplicated
	GSA A	GSA B	GSA C	
Family Practice/General Medicine	276	266	317	750
Pediatrics	214	179	151	491
Nurse Practitioners	135	292	243	597
Internal Medicine[1]	279	256	258	736
OB/GYN[1]	10	11	38	55
RHC/FQHC	1	7	8	14

Data source: Network Adequacy Review 2016 Q2

Geographic Service Area: A: New Orleans and North Shore; B: Baton Rouge, Lafayette and Thibodaux; C: Alexandria, Lake Charles, Monroe and Shreveport

[1] Accepts full PCP responsibility.

Provider Network Accessibility

Aetna monitors its provider network for accessibility and network capability using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. Table 4 shows the percentage of members for whom geographic access standards were met.

Table 4: GeoAccess Provider Network Accessibility as of July 11, 2016

Provider Type		Access Standard[1] X Provider(s) within X Miles	Percentage of Members for Whom Standard was Met
Family Practitioners and General Practitioners	Urban	1 within 20 miles	99.7%
	Rural	1 within 30 miles	100.0%
Internal Medicine	Urban	1 within 20 miles	98.4%
	Rural	1 within 30 miles	97.8%
Pediatricians	Urban	1 within 20 miles	98.1%
	Rural	1 within 30 miles	97.4%
Nurse Practitioners	Urban	1 within 20 miles	99.6%
	Rural	1 within 30 miles	99.1%
OB/GYN	Urban	1 within 20 miles	88.5%
	Rural	1 within 30 miles	60.3%
RHCS/FQHC	Urban	1 within 20 miles	59.0%
	Rural	1 within 30 miles	54.9%

[1] The Access Standard is measured in distance to member address.

IV. QUALITY INDICATORS

To measure quality of care provided by the Health Plans, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including Performance Improvement Projects (PIPs), as well as HEDIS® and CAHPS®.

Performance Improvement Projects

A Performance Improvement Project (PIP) is intended to improve the care, services or member outcomes. The LDH selects PIP topics that address specific areas of concern to the Medicaid population in the state and the projects are conducted by the Health Plans in a collaborative, facilitated by the LDH, the University of Louisiana Monroe and IPRO. All Health Plans are required to use the same basic methodology and report the same metrics so that the LDH will be able to aggregate results and report them statewide.

During this reporting period, each Health Plan was required to perform two (2) State-approved collaborative PIPs: Reducing Premature Births and the Identification and Treatment of Adolescents with ADHD.

In accordance with 42 CFR 438.358, IPRO conducted a review and validation of the Reducing Premature Birth PIP using methods consistent with the CMS protocol for validating performance improvement projects. The identification and Treatment of ADHD PIP was introduced in reporting year 2016 during which the Health Plans submitted their proposals but did not yet report any findings. Validation of this PIP will occur in 2017.

Summaries of each of the PIPs conducted by Aetna follow.

State-Directed Collaborative PIP: Reducing Premature Births

Indicators, Baseline Rates and Goals: The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final re-measurement are as follows:

- Initiation of injectable progesterone for preterm birth prevention: increase from 9.2% to 20%
- Use of most effective contraceptive methods: increase from 7.7% to 15%
- Chlamydia test during pregnancy: increase from 72.4% to 76%
- HIV test during pregnancy: increase from 70.3% to 74%
- Syphillis test during pregnancy: increase from 73.6% to 76%
- HEDIS® *Postpartum Care* measure: increase from 58.28% to 63.12%

Intervention Summary:

Member:

- Care Managers will facilitate appointment scheduling, transportation, discuss 17P
- Care Managers will discuss importance of STI screening and postpartum visits
- Care Managers will educate members on the Text4Baby Program

Provider:

- Implementation of high risk registry communication from plan to provider
- Provide OB Toolkit for provider education regarding 17P, STI screenings, Notice of Pregnancy (NOP) form, coding for contraception
- Medicaid 101: Collaborate with LDH and other Bayou Health MCOs to develop workshops for PCPs

MCO:

- Identify and track pregnant women who qualify as a candidate for progesterone therapy and are part of the at risk subpopulations through an internal registry, outreach questionnaires, reports and referrals
- CMO and Care Manager Director to stratify for care intervention based upon a review of LEERS/High Risk Registry files for history of pre-term birth
- Compare current pregnancy case management cases to claims data for members with positive pregnancy diagnosis to identify high risk pregnant women for outreach

Overall Credibility of Results: There are no validation findings that indicate that the credibility of the study is at risk.

Strengths:

- Implementation and monitoring of interventions designed to improve plan performance of measures related to reducing preterm birth.

Opportunities for Improvement:

- Monitor, report and interpret monthly/quarterly trends/patterns for intervention tracking (process) measures in order to identify what is working, what is not working, and why, e.g., barriers.
- Refine interventions to address identified barriers.

State-Directed Collaborative PIP: Treatment of Adolescents with ADHD

This PIP aims to improve the quality of care received by children with ADHD by implementing a robust set of health plan, member, and community and provider interventions to improve rates of evaluation, diagnosis, management and treatment of ADHD consistent with clinical practice guidelines recommendations. Hybrid performance measures based upon a random sample of children will be used to assess diagnosis, evaluation and care coordination in accordance with guidelines recommendations. Administrative measures based upon the population newly prescribed ADHD medication will be used to assess compliance with medication monitoring standards in accordance with the HEDIS® measure, *Follow-Up Care for Children Prescribed ADHD Medication (ADD)*. In addition, encounter and pharmacy data will be used to assess receipt of behavioral therapy for children with ADHD who are on psychotropic medication.

Intervention Summary:

- Develop the provider network by recruiting trained providers or training new providers trained in Evidence-Based Practice (EBP) Practices
- Link children younger than six years of age to EBP therapists
- MCOs and the LDH collaborate to produce and distribute a PCP toolkit
- MCOs and the LDH collaborate to develop strategy to expand access to in-person or telephonic case consultation to PCPs
- Enhance Case Management to facilitate behavioral health referrals; to foster care plan collaboration among care managers, PCPs behavioral therapists, teachers, parents and children; and to increase PCP practice utilization of on-site care coordination and/or MCO care coordination

Results: Not yet available.

Performance Measures: HEDIS® 2016 (Measurement Year 2015)

MCO-reported performance measures were validated as per HEDIS® 2016 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2016 Compliance Audit are summarized in its Final Audit Report (FAR).

The HEDIS® 2016 FAR prepared for Aetna by Advent Advisory Group indicates that the Health Plan demonstrated compliance with all areas of Information Systems and all areas of measure determination required for successful HEDIS® reporting.

HEDIS® Effectiveness of Care Measures

HEDIS® Effectiveness of Care measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. Table 5 displays Health Plan performance rates for select HEDIS® Effectiveness of Care measures for HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 5: HEDIS® Effectiveness of Care Measures – 2016

Measure	Aetna	QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS®2016		
Adult BMI Assessment	SS	-	75.92%
Antidepressant Medication Management - Acute Phase	87.72%	95th	53.52%
Antidepressant Medication Management - Continuation Phase	84.21%	95th	38.09%
Asthma Medication Ratio (5-64 Years)	SS	-	54.09%
Breast Cancer Screening in Women	SS	-	55.55%
Cervical Cancer Screening	30.77%	<10%	57.08%
Childhood Immunization Status - Combination 3	42.86%	<10%	64.37%
Chlamydia Screening in Women (16-24 Years)	62.73%	90th	60.98%
Comprehensive Diabetes Care - HbA1c Testing	79.47%	10th	80.01%
Controlling High Blood Pressure	33.80%	10th	40.96%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	SS	-	55.69%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	SS	-	43.71%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	SS	-	24.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	41.18%	10th	46.06%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	39.53%	10th	45.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	27.76%	10th	31.83%

SS: Sample size too small to report (less than 30 members) but included in the statewide average).

HEDIS® Access to/Availability of Care Measures

The HEDIS® Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women and adults who receive PCP/preventive care services, ambulatory care (adults only) or receive timely prenatal and postpartum services. Table 6 displays Health Plan rates for select HEDIS® Access to/Availability of Care measure rates for HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 6: HEDIS® Access to/Availability of Care Measures – 2016

Measure	Aetna	QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS®2016		
	Children and Adolescents' Access to PCPs		
12–24 Months	76.58%	<10th	95.45%
25 Months–6 Years	68.04%	<10th	85.49%
7–11 Years	SS	-	87.17%
12–19 Years	SS	-	86.14%
	Adults' Access to Preventive/Ambulatory Services		
20–44 Years	68.22%	10th	78.48%
45–64 Years	81.17%	10th	87.30%
65+ Years	70.15%	10th	77.92%
	Access to Other Services		
Timeliness of Prenatal Care	71.79%	10th	80.05%
Postpartum Care	58.28%	33.33rd	60.19%

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

HEDIS® Use of Services Measures

This section of the report explores utilization of Aetna's services by examining selected HEDIS® Use of Services rates. Table 7 displays Health Plan rates for select HEDIS® Use of Services measure rates for HEDIS® 2016, Bayou Health 2016 statewide averages and *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 7: Use of Services Measures – 2016

Measure	Aetna	QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded	2016 Statewide Average
	HEDIS®2016		
Adolescent Well-Care Visit	31.71%	<10th	51.51%
Ambulatory Care Emergency Department Visits/1000 Member Months[1]	90.22	90th	71.60
Ambulatory Care Outpatient Visits/1000 Member Months	427.94	75th	413.62
Frequency of Ongoing Prenatal Care - ≥ 81%	63.17%	50th	68.71%
Well-Child Visits in the First 15 Months of Life 6+ Visits	SS	-	57.48%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	41.94%	<10th	63.59%

[1] A lower rate is desirable.

SS: Sample size too small to report (less than 30 members) but included in the statewide average.

Member Satisfaction: Adult and Child CAHPS® 5.0H

In 2016, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H surveys of Adult Medicaid members and Child Medicaid with Chronic Care Conditions (CCC) was conducted on behalf of Aetna by the NCQA-certified survey vendor, Center for the Study of Service (CSS). Table 8 and Table 9 show Aetna's CAHPS® rates for 2016, as well as *Quality Compass*® 2016 South Central – All Lines of Business (LOB) (Excluding PPOs and EPOs) Medicaid benchmarks.

Table 8: Adult CAHPS® 5.0H – 2016

Measure[1]	Aetna	QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	
Getting Needed Care	79.72%	33.33rd
Getting Care Quickly	81.09%	50th
How Well Doctors Communicate	87.25%	<10th
Customer Service	83.18%	<10th
Shared Decision Making	80.17%	50th
Rating of All Health Care	74.34%	50th
Rating of Personal Doctor	77.11%	10th
Rating of Specialist	81.08%	50th
Rating of Health Plan	72.47%	25th

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".

Table 9: Child CAHPS® 5.0H General Population – 2016

Measure[1]	Aetna	QC 2016 South Central – All LOBs (Excluding PPOs/EPOs) Medicaid Benchmark Met/Exceeded
	CAHPS® 2016	
Getting Needed Care	86.14%	66.67th
Getting Care Quickly	88.97%	33.33rd
How Well Doctors Communicate	94.78%	75th
Customer Service	SS	-
Shared Decision Making	SS	-
Rating of All Health Care	80.32%	<10th
Rating of Personal Doctor	87.23%	33.33rd
Rating of Specialist	SS	-
Rating of Health Plan	78.77%	10th

[1] Note: for "Rating of" measures, Medicaid rates are based on ratings of 8, 9 and 10; for measures that call for respondents to answer with "Always," "Usually," "Sometimes" or "Never" the Medicaid rate is based on responses of "Always" or "Usually".

SS: Small sample (less than 100 responses).

V. COMPLIANCE MONITORING

Medicaid Compliance Audit Findings for Contract Year 2016

In 2016, IPRO conducted the 2016 Compliance Audit on behalf of the LDH. Full compliance audits occur every three years, with partial audits occurring within the intervening years. The 2016 Compliance Audit was a full audit of Aetna's compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

The 2017 Compliance Audit included a comprehensive evaluation of Aetna's policies, procedures, files and other materials corresponding to the following nine (9) domains:

1. Core Benefits and Services
2. Provider Network
3. Utilization Management
4. Eligibility, Enrollment and Disenrollment
5. Marketing and Member Education
6. Member Grievances and Appeals
7. Quality Management
8. Reporting
9. Fraud, Waste and Abuse

The file review component assessed Aetna's implementation of policies and its operational compliance with regulations in the areas of appeals, behavioral health care management, case management, information reconsiderations, member grievances, provider credentialing and recredentialing, and utilization management denials.

For this audit, determinations of full compliance, substantial compliance, minimal compliance and compliance not met were used for each element under review. Definitions for these review determinations are presented in Table 10.

Table 10: 2016 Compliance Audit Determination Definitions

Determination	Definition
Full	The MCO has met or exceeded the standard
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

Findings from Aetna's 2016 Compliance Review follow. Table 11 displays the total number of requirements reviewed for each domain, as well as compliance determination counts for each domain.

Table 11: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	Not Applicable	% Full
Core Benefits and Services	123	114	8	1	0	0	93%
Provider Network	163	145	16	1	1	0	89%
Utilization Management	92	39	52	0	0	1	43%
Eligibility, Enrollment and Disenrollment	13	12	1	0	0	0	92%
Marketing and Member Education	77	74	2	0	1	0	96%
Member Grievances and Appeals	62	52	10	0	0	0	84%
Quality Management	86	81	3	0	0	2	96%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	105	0	0	0	0	100%
Total	722	623	92	2	2	3	87%

It is IPRO's and the LDH's expectation that Aetna submit a corrective action plan for each of the 96 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that Aetna has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. Eighteen (18) of the 96 elements rated less than fully complaint relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to Aetna.

VI. STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT & RECOMMENDATIONS

This section summarizes the accessibility, timeliness and quality of services provided by Aetna to Medicaid recipients based on data presented in the previous sections of this report. The Plan's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted.

Strengths

- The 2016 HEDIS® Final Audit Report revealed no significant problems and the Health Plan was able to report all required Medicaid rates.
- The Health Plan exceeded the 75th percentile for the following HEDIS® measures: *Antidepressant Medication Management – Acute Phase*, *Antidepressant Medication Management – Continuation Phase* and *Chlamydia Screening in Women*.
- The Health Plan met the 75th percentile on a single CAHPS® measure for the Child General Population: *How Well Doctors Communicate*.
- In regard to the 2016 Compliance Review, the Health Plan demonstrated strong performance in two (2) of the nine (9) domains, as it achieved "full" compliance for elements reviewed in these domains.

Opportunities for Improvement

- The Health Plan demonstrates an opportunity for improvement in regard to its overall HEDIS® performance. The following measures performed below the 50th percentile: *Cervical Cancer Screening*, *Childhood Immunization Status – Combo 3*, *Comprehensive Diabetes Care – HbA1c Testing*, *Controlling High Blood Pressure*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity*, *Timeliness of Prenatal Care*, *Postpartum Care*, *Adolescent Well-Care Visit* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*.
- The Health Plan demonstrates an opportunity for improvement in regard to its overall CAHPS® performance. The following Adult Population measures performed below the 50th percentile: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor* and *Rating of Health Plan*. Additionally, the Plan reported the following Child General Population measures below the 50th percentile: *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor* and *Rating of Health Plan*.
- In addition, the Health Plan demonstrates an opportunity for improvement in regard to access to care as rates for all reported age groups were below the 50th percentiles for the HEDIS® *Children and Adolescents Access to PCPs* and *Adults' Access to Preventive/Ambulatory Services* measures.

Recommendations

- The Health Plan should conduct root cause analysis for all HEDIS® Effectiveness of Care and Use of Services measures that performed below the 50th percentile and develop interventions to address identified barriers to care. The Health Plan should also routinely monitor HEDIS® performance to assess the effectiveness of its improvement strategy.
- As Health Plan members demonstrates lower than average access to primary care, a root cause analysis should be conducted to identify barriers to care for all age groups and to drive the development of targeted interventions that will address these barriers.
- The Health Plan should conduct root cause analysis for CAHPS® measures performing below the 50th percentile and implement interventions to address these measures.

Response to Previous Year's Recommendations

- 2014-2015 Recommendation: The Plan should report performance measures to the DHH that allow for the evaluation of the quality of, access to and timeliness of care, specifically, as it relates to its Medicaid population.

  Health Plan Response: Aetna currently evaluates and monitors performance using HEDIS.

- 2014-2015 Recommendation: The Plan should report performance measures to the DHH that allow for the evaluation of Medicaid member satisfaction.

  Health Plan Response: Aetna currently evaluates and monitors member satisfaction using CAHPS, a Behavioral Health Satisfaction Survey and through member grievance activity.