



HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	0704.460
Policy Title	CLIENT PROBLEM RESOLUTION PROCESS
Program	PERFORMANCE MANAGEMENT UNIT - QUALITY IMPROVEMENT
Affects	ALL BHP AND DMC-ODS PROGRAMS
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PURPOSE

Humboldt County Department of Health and Human Services - Behavioral Health (DHHS-BH) assures that individuals receive thoughtful and timely response and resolution to requests for problem resolution, including Grievances, Appeals, Requests for Change of Provider, and Requests for Second Opinion.

Clients, or Providers acting on their behalf, shall not be subject to any cost penalty or discrimination for initiating a request, Grievance, or Appeal.

DEFINITION(S)

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an “adverse benefit determination” (see below). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary’s rights regardless of whether remedial action is requested, and the beneficiary’s right to dispute an extension of time proposed by the Plan to make an authorization decision. There is no distinction between an informal and formal grievance.

Discrimination Grievance: A concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Appeal: A request for review of an Adverse Benefit Determination.

Adverse Benefit Determination: An “Adverse Benefit Determination” occurs when the DHHS-BH, while acting as the MHP for the County, takes any of the following actions:

1. The denial or limited authorization of requested services, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit ([1045 – Denial](#), [1045 – Delivery System](#));
2. The reduction, suspension, or termination of a previously authorized service ([1045 – Modification](#), [1045 – Termination](#));
3. The denial, in whole or in part, of payment for a service ([1045 – Payment Denial](#));
4. The failure to provide services in a timely manner ([1045 – Timely Access](#), [1045 – Authorization Delay](#));
5. The failure to act within the required timeframes for standard resolution of grievances and appeals ([1045 – Failure to Timely Resolve Grievances and Appeals](#)); or
6. The denial of a beneficiary’s request to dispute financial liability ([1045 – Financial Liability](#)).

Request for Change of Provider: A request by a client to change treatment provider, whether physician, clinician, or Case Manager, within DHSS-BH or a contract provider. Responses will be sent to clients within fifteen (15) working days.

Request for Second Opinion: A request by a client for review of a decision regarding medical necessity criteria or type or level of service [a Notice of Adverse Benefit Determination (NOABD) situation], or review of diagnosis or treatment regimen. Responses will be sent to clients within fifteen (15) working days.

Trans-inclusive health care: Also known as TGI (transgender, gender diverse, or intersex) care, is defined as comprehensive health care that aligns with established standards of care for individuals who identify as transgender, gender diverse, or intersex. This approach to care emphasizes the importance of honoring each person's bodily autonomy, avoiding assumptions about gender identity, and embracing gender fluidity and nontraditional gender presentations. TGI care requires providers to treat all individuals with compassion, respect, and understanding, ensuring that behavioral health services are affirming, inclusive, and responsive to the unique needs and experiences of TGI individuals.

POLICY

During the process of responding to and resolving clients' requests, their rights to confidentiality shall be respected by all staff involved. The Quality Improvement Coordinator (QIC) or designee will coordinate, facilitate, log and track all requests for problem resolution. The QIC or designee is the assigned staff member responsible for responding to clients' questions regarding the status of their requests for problem resolution. Trended data from the problem resolution process shall be utilized in the Quality Improvement program to improve quality of care.

Through this policy, DHHS-BH shall ensure compliance with all TGI-related grievance monitoring and training reporting requirements as specified in BHIN 25-019. This includes tracking grievances related to failure to provide trans-inclusive care and reporting such data to DHCS on a quarterly basis.

PROCEDURE

All Requests for Problem Resolution will be logged, tracked and reported by the QIC or designee to the Quality Improvement Committee on a quarterly basis. The QIC or designee shall be responsible for all reports to the State about the Problem Resolution process.

1. Clients may authorize another person to act on their behalf in the Grievance and Appeal process, and they may also request that a staff member assist them. The Quality Improvement Coordinator or designee will assign a staff member in those cases.
2. Grievances or Appeals may be made verbally or in writing by a client, family member, or other client representative, to the Quality Improvement Coordinator or designee, a staff member, or the Patients' Rights Advocate.
 - 2.1. If the problem involves an Adverse Benefit Determination, the Problem Resolution request shall be treated as an Appeal (see Policy No. 0704.500).
3. Problem Resolution Forms and self-addressed envelopes will be available at all Provider sites so that the clients may obtain them without having to make a verbal request. Information about the problem resolution process, including the availability of fair hearings, is included in the beneficiary handbook and offered to all new clients at intake (see form 1196–Informing Materials Packet–Client Acknowledgement) and is present at all provider sites.
4. Resolution of problems may be reached through discussion between the client or client representative and any staff member. Every effort will be made to resolve problems at this level.

5. Grievance

- 5.1. Clients may present Grievances either orally or in writing. Clients are encouraged to utilize, but not required to use, the Client Problem Resolution Form. If clients do not wish to use the Form, they may call the QIC or designee directly at (707) 268-2955, option 2, or any DHHS-BH staff may complete the Form for them. If necessary, a Release of Information Form (ROI) will be obtained from the client by the QIC or designee. The client may submit other written materials with the Grievance and may also request to review their own records.

- 5.2. Grievances and Appeals are documented and tracked by the Quality Improvement Unit in the BH Client Concern Database. The QIC or designee will enter the Problem Resolution request into the BH Client Concern Database within one (1) working day of receipt.
- 5.2.1. The Log information will include at a minimum:
- 5.2.1.1. The date and time of receipt of the grievance or appeal;
 - 5.2.1.2. The name of the member filing the grievance or appeal;
 - 5.2.1.3. The name of the representative recording the grievance or appeal;
 - 5.2.1.4. A description of the complaint or problem;
 - 5.2.1.5. A description of the action taken by the BHP or provider to investigate and resolve the grievance or appeal;
 - 5.2.1.6. The proposed and final resolution by the BHP or provider;
 - 5.2.1.7. The name of the BHP provider or staff responsible for resolving the grievance or appeal; and
 - 5.2.1.8. The date of notification to the member of the resolution.
 - 5.2.1.9. The date of each review or review meeting (if applicable),
 - 5.2.1.10. The resolution information at each level of the problem (if applicable); and the date of resolution at each level of the problem (if applicable).
- 5.2.2. The Log shall document resolution of the problem within thirty (30) calendar days of its receipt, as well as the date the decision was sent to the client, or the reason why the problem could not be resolved.
- 5.2.3. The Quality Improvement Unit will issue a reminder letter one (1) week prior to due date to managers or supervisors who have Grievances or appeals that have not been resolved. If any Grievances or Standard Appeals are still outstanding within one week of the due date, Quality Improvement will notify Behavioral Health Administration (Director or Deputy Director) who will follow up with the responsible manager or supervisor to ensure resolution within the timeframe.
- 5.3. The QIC or designee will write a letter to the client acknowledging the receipt of the Grievance and explaining the Grievance process, within five (5) calendar days of receipt by the QIC or designee. The notification letter which is sent to the client is copied and kept with the original Grievance or Appeal form, and the date of the notification is noted in the Database.
- 5.3.1. The acknowledgement shall include the date of receipt, as well as the name, telephone number, and address of the MHP representative who the beneficiary may contact about the grievance.
- 5.4. If the Client Problem Resolution Form has not been completed, the QIC or designee will complete the Form. The Form (and any other documentation the client has submitted) will be sent to the appropriate Manager or Supervisor (Director, Deputy Director, Medical Director, Director of Nurses, Sr. Program Manager, Supervising Clinician) within one (1) working day of receipt by the QIC or designee. If the appropriate Manager or Supervisor was involved in the subject that is being grieved, another Manager will be designated to investigate the Grievance.
- 5.5. Upon receipt of the Form from the QIC or designee, the Manager or designee will investigate the problem in conjunction with other staff as necessary (only staff who is not involved in the issue being grieved) and will initiate and hold a discussion with the client and/or representative to resolve the problem.
- 5.5.1. The Grievance must be investigated and resolved within thirty (30) calendar days, unless the client requests more time, or there are other circumstances justifying a reason to delay. DHHS-BH may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the beneficiary requests an extension, or if DHHS-BH determines that there is a need for additional information and the delay is in the beneficiary's interest. If the timeframe is extended not at the request of the beneficiary, DHHS-BH will make reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within two (2) calendar days of the decision to extend the timeframe. This written notice of extension shall inform the beneficiary of the right to file a grievance if they disagree with DHHS-BH's decision. This notice is not a Notice of Adverse Benefit Determination. DHHS-BH may extend the timeframe for an additional fourteen (14) calendar days if the beneficiary requests the extension or DHHS-BH demonstrates a need for additional information and how the delay is in the beneficiary's best interest.

5.5.2.QIC or designee is responsible for sending Notice of Adverse Benefit Determination 1045 – Failure to Timely Resolve Grievances and Appeals NOABD when MHP fails to act within the timeframe for disposition for Grievances, see Policy Number 0704.500.

5.6. The Manager or designee who is responsible for the investigation will notify the client in writing of the resolution using the QI-115 Notice of Grievance Resolution form, which shall contain a summary of the grievance filed by the member, steps taken to resolve the grievance (e.g., investigation, speaking with provider), a clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the member, and the reasons for the decision. The following attachments will be included with all QI-115 Notice of Grievance Resolution forms: QI-109 Nondiscrimination, QI-110 Language Assistance, and QI-112 NAR Your Rights. If grievance is regarding staff, then Manager or Supervisor investigating the grievance must notify the staff grieved about of the disposition using the QI-105 Letter to Provider. The Manager will also send the documentation of the resolution to the QIC or designee (original of the Problem Resolution Form, copy of the QI-115 Notice of Grievance Resolution sent to member, and copy of the QI-105 Letter to Provider (if applicable).

5.7. The Manager may notify clients who do not have a permanent mailing address either in person or by telephone with written documentation of the discussion.

5.8. For clients who have been working with billing (Claims Data Management) and are not satisfied:

5.8.1.Billing will refer the client to the Managed Care Line.

5.8.2.QI will collect information about the client from the Electronic Health Record and billing. This process may take one to two days.

5.8.3.QI will contact Claims Data Management to determine what has already been done to assist the client. If a rate adjustment might be warranted the matter will be discussed with the QIC or designee or PMU Manager.

5.8.4.The QIC will notify the client by telephone of the status of their inquiry. If the client is still not satisfied, the client may file a Grievance.

5.8.5.The Grievance will be managed in the usual manner and will be tracked in a Finance Grievance Log binder separate from other grievances.

5.9. Grievances Related to Trans-Inclusive Care

5.9.1.Grievances involving failure to provide trans-inclusive care (as defined in W&I Code §14197.09) shall be:

5.9.1.1. Logged as TGI-related in the Client Concern Database.

5.9.1.2. Investigated and resolved following all standard grievance procedures.

5.9.1.3. Tracked separately and reported to DHCS quarterly.

5.9.1.4. If the grievance is resolved in the member's favor, the individual(s) named must complete a refresher of the DHHS-BH-approved trans-inclusive health care cultural competency training within 45 calendar days and before any further direct contact with members.

5.9.2.The QIC or designee shall report the following elements to DHCS quarterly:

5.9.2.1. Total number of trans-inclusive care grievances received

5.9.2.2. Total number resolved in favor of the member

5.9.2.3. Dates of receipt and resolution

5.9.2.4. Name, position, and affiliation of individual(s) involved

5.9.2.5. Refresher training completion dates

5.9.2.6. Any corrective actions taken to prevent recurrence

5.9.3.The QIC or designee will ensure all documentation of Discrimination Grievances is sent to DHCS Office of Civil Rights within ten (10) calendar days of mailing the grievance resolution. For grievances involving denial of trans-inclusive care, the QIC or designee shall additionally follow the BHIN 25-019 reporting instructions and timelines, ensuring submission of quarterly reports to QAPIS@dhcs.ca.gov.

6. Discrimination Grievance

- 6.1. Clients may present Discrimination Grievances either orally or in writing. Clients are encouraged to utilize, but not required to use, the Client Problem Resolution Form. If clients do not wish to use the Form, they may call the QIC or designee directly at (707)268-2955, option 2, or staff may complete the Form for them. If necessary, a Release of Information Form (ROI) will be obtained from the client by the QIC or designee. The client may submit other written materials with the Grievance and may also request to review their own records.
- 6.2. QIC or designee will monitor incoming grievances for discrimination content - concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
- 6.3. Discrimination Grievances will be assigned to Discrimination Grievance Coordinator/QIC who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
- 6.4. Discrimination Grievances are documented and tracked by the Quality Improvement Unit on the Client Concern Database. The QIC or designee will enter the Problem Resolution request into the Client Concern Database within one (1) working day of receipt. The Database information will include the name of the client, the date of receipt, the nature of the problem, the time period allowed for resolution, the staff member responsible, the date of each review or review meeting (if applicable), resolution information at each level of the problem (if applicable), the date of resolution at each level of the problem (if applicable), and the date required documentation was sent to the DHCS Office of Civil Rights. The Log shall document resolution of the problem within thirty (30) calendar days of its receipt, as well as the date the decision was sent to the client, or the reason why the problem could not be resolved.
- 6.5. If the Client Problem Resolution Form has not been completed, the QIC or designee will complete the Form. The Form (and any other documentation the client has submitted) will be sent to the Discrimination Grievance Coordinator within one (1) working day of receipt by the QIC or designee.
- 6.6. The QIC or designee will write a letter to the client acknowledging the receipt of the Discrimination Grievance and explaining the Discrimination Grievance process, within five (5) calendar days of receipt by the QIC or designee. The notification letter which is sent to the client is kept with the original Discrimination Grievance form, and the date of the notification is noted on the Database.
 - 6.6.1. The acknowledgement shall include the date of receipt, as well as the name, telephone number, and address of the Discrimination Grievance Coordinator who the beneficiary may contact about the grievance.
- 6.7. The Quality Improvement Unit will issue a reminder letter to the Discrimination Grievance Coordinator one (1) week prior to due date. QIC or designee will enter this date in the Client Concern Database.
- 6.8. Upon receipt of the Client Concern form from the QIC or designee, the Discrimination Grievance Coordinator will investigate the problem in conjunction with other staff as necessary (only staff who is not involved in the issue being grieved) and will initiate and hold a discussion with the client and/or representative to resolve the problem.
- 6.9. The Discrimination Grievance must be investigated and resolved within thirty (30) calendar days, unless the client requests more time, or there are other circumstances justifying a reason to delay.
 - 6.9.1.1. DHHS-BH may extend the timeframe for processing a Discrimination grievance by up to fourteen (14) calendar days if the beneficiary requests an extension, or if DHHS-BH determines that there is a need for additional information and the delay is in the beneficiary's interest. If the timeframe is extended not at the request of the beneficiary, DHHS-BH will make reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within two (2) calendar days of the decision to extend the timeframe. This written notice of extension shall inform the beneficiary of the right to file a grievance if they disagree with DHHS-BH's decision. This notice is not a Notice of Adverse Benefit

Determination. DHHS-BH may extend the timeframe for an additional fourteen (14) calendar days if the beneficiary requests the extension or DHHS-BH demonstrates a need for additional information and how the delay is in the beneficiary's best interest.

6.9.1.2. QIC or designee is responsible for sending Notice of Adverse Benefit Determination 1045 – NOABD Failure to Timely Resolve Grievance/Appeal when MHP fails to act within the timeframe for disposition for Grievances, see Policy Number 0704.500.

6.9.1.3. The Discrimination Grievance Coordinator who is responsible for the investigation and will notify the client in writing of the resolution using the QI-115 Notice of Grievance Resolution form, which shall contain a summary of the grievance filed by the member, steps taken to resolve the grievance (e.g., investigation, speaking with provider), a clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the member, and the reasons for the decision. The following attachments will be included with all QI-115 Notice of Grievance Resolution forms: QI-109 Nondiscrimination, QI-110 Language Assistance, and QI-112 NAR Your Rights.

6.9.1.4. If grievance is regarding staff, then person investigating the grievance must notify the staff grieved about of the disposition using the QI-105 Letter to Provider. The Discrimination Grievance Coordinator will also send the documentation of the resolution to the QIC or designee (original of the Problem Resolution Form, copy of the QI-115 NGR mailed to client with attachments, and copy of the QI-105 Letter to Provider (if applicable).

6.10. If a grievance is decided in the member's favor, the applicable individual(s) must complete the trans-inclusive health care cultural competency training within 45 days from the grievance resolution and before having direct contact with members

6.11. The QIC or designee will ensure Discrimination Grievance documentation are sent to DHCS Office of Civil Rights within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to beneficiary.

6.11.1. The following will be included:

6.11.1.1. The original complaint.

6.11.1.2. The provider's or other accused party's response to the complaint.

6.11.1.3. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the MHP.

6.11.1.4. Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.

6.11.1.5. All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.

6.11.1.6. The results of the MHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

6.11.1.7. QIC or designee will enter the date the required documentation was sent to the DHCS Office of Civil Rights in the Client Concerns Database.

7. Appeal

7.1. For appeals or expedited appeals of adverse benefit determinations, see Policy No. 0704.500 Notice of Adverse Benefit Determination for details on the Appeal and Expedited Appeal Process.

7.2. For grievances that are "appealed" because the client is not satisfied with the resolution of the grievance, this is treated as a second grievance and follows the same general process as detailed in section 5. The only difference is that the resolution of this secondary grievance is completed by a person other than the one who resolved the original grievance. These are also usually escalated to a higher level of management/administration.

7.3. For appeals involving trans-inclusive care determinations, all resolution and follow-up training requirements outlined in BHIN 25-019 shall apply if the case is decided in favor of the beneficiary.

8. Requests for Culture-Specific Provider

- 8.1. Upon receipt of the request for access to services with the beneficiary's preference for a culture-specific Provider, and after determining that (A) it is a non-emergency request, and (B) client meets medical necessity.
- 8.2. The beneficiary will be given an alphabetical list of up to five (5) possible providers and asked to choose one.
- 8.3. The Access staff will then contact Provider and arrange for authorization or referral.
- 8.4. The beneficiary will be notified accordingly.

9. Requests for Change of Provider and Second Opinion

9.1. Request for Change of Provider

- 9.1.1. Upon notification of a Request for Change of Provider, the involved clinical or support staff member will request the individual to complete the Request for Change of Provider Form, with assistance from staff as necessary.
- 9.1.2. The Form will be forwarded to the QIC or designee. Upon the receipt of the Form, the QIC or designee will log the request and forward the Form within one working day to the appropriate Manager for resolution.
- 9.1.3. If the Change of Provider Request includes an expression of dissatisfaction, the Change of Provider Request will be logged as a Change of Provider Request with Grievance. If the Change of Provider Request does not include an expression of dissatisfaction, the Change of Provider Request will be logged as a Change of Provider Request.
- 9.1.4. The Manager or designee will investigate the request and make a determination in conjunction with other staff as necessary.
- 9.1.5. After the determination is made, the client and the provider(s) will be notified of the decision by the Manager or designee within fifteen working days of the initial receipt. A copy of the Form with the disposition will be forwarded to the QIC. A letter will be sent to the client to confirm approval of Change of Provider Request and a copy of the letter will be sent to QI.
 - 9.1.5.1. If the Change of Provider Request includes an expression of dissatisfaction, the resolution letter will additionally address the complaints made by the consumer using the QI-115 Notice of Grievance Resolution.

9.2. Request for Second Opinion

- 9.2.1. DHSS-BH will provide for a Second Opinion from a qualified care professional within Mental Health Plan (MHP) network or will arrange for the beneficiary to obtain a second opinion outside the Mental Health Plan Network at no cost to the beneficiary.
- 9.2.2. The client will fill out the Request for Second Opinion Form with assistance from the staff as necessary. The Form will be forwarded to the QIC or designee. Upon receipt, the QIC or designee will log the request and forward the Form to the appropriate Manager.
- 9.2.3. The Manager or designee will assign a licensed behavioral health professional with the same level of professional licensure as the person who made the initial decision to perform a second assessment, using the Second Opinion Review Form. The assigned staff will have no prior involvement with their current course of treatment. If medication issues are involved in the disagreement, the Medical Director or designee will be involved as well. This assessment may be done as a face-to-face, telephone interview, and/or review of records.
- 9.2.4. The Manager or designee will forward the completed Second Opinion Form to the QIC or designee. If the second opinion assessment agrees with the initial decision, the client (and provider as appropriate) will be notified of the decision in writing by the QIC or designee within fifteen working days of the date of the second assessment. The client will be referred to the Grievance or Appeal process if a dispute remains.

9.2.5. If the Second Opinion assessment does not agree with the initial determination (which may mean that medical necessity was found) the client (and provider as appropriate) will be notified in writing by the QIC or designee within fifteen working days of the change of decision. Assigned clinical staff will then authorize the change in services as necessary.

FORM(s)/ATTACHMENTS

[QI-25 Client Problem Resolution Guide](#)
[QI-27 Request for Second Opinion Cover](#)
[QI-28 Request for Second Opinion Form](#)
[QI-29 Request for Change of Service Provider Cover](#)
[QI-30 Request for Change of Service Provider Form](#)
[QI-31 Client Problem Resolution Guide \(Spanish version\)](#)
[QI-32 Client Problem Resolution Request Form \(Spanish version\)](#)
[QI-33 Request for Second Opinion Cover \(Spanish version\)](#)
[QI-34 Request for Second Opinion Form \(Spanish version\)](#)
[QI-35 Request for Change of Service Provider Cover \(Spanish version\)](#)
[QI-36 Request for Change of Service Provider Form \(Spanish version\)](#)
[QI-57a Client Problem Resolution Request Form-Client](#)
[QI-57b Client Problem Resolution Request Form-Staff](#)
[QI-109 Nondiscrimination](#)
[QI-110 Language Assistance](#)
[QI-112 NAR Your Rights](#)
[QI-105 Letter to Provider](#)
[QI-115 Notice of Grievance Resolution](#)
[1045 NOABD Failure to Timely Resolve Grievances and Appeals](#)
[DHCS TGI Quarterly Grievance Report Template](#)

REFERENCE

[Behavioral Health Information Notice No: 25-014](#)
[CEC Section 1157](#)
[CWIC Section 4070](#)
[CCR Title 9, Div. 1, Chapter 11, Subchapter 1, Art. 4, Section 1810.405 \(e\)](#)
[CCR Title 9, Div. 1, Chapter 11, Subchapter 5, Art. 1, Sections 1850.205 through 1850.208](#)
[CCR Title 9, Div. 1, Chapter 11, Subchapter 5, Art. 2, Sections 1850.215](#)
[CCR Title 22, Div. 3, Subdivision 1, Chapter 3, Art. 1.3, Section 51014.2](#)
[CCR Title 28, Div. 1, Chapter 2, Art. 8, Section 1300.70](#)
[42 CFR Sections 438.206 \(b\) & 438.228](#)
[42 CFR Sections 438.400 through 438.424*](#)
[CFR title 42 Section 438.408\(e\)\(1\),\(2\) *](#) (as modified by the waiver renewal request of August 2002 and CMS letter, August 22, 2003.)