

OFFICE OF ADMINISTRATIVE LAW



In re: ) 1998 OAL Determination No. 22  
 Request for Regulatory )  
 Determination filed by DIANE ) [Docket No. 91-024]  
 S. CAMPBELL regarding )  
 various Medi-Cal Provider ) September 22, 1998  
 Bulletins and memos issued )  
 by the DEPARTMENT OF ) Determination Pursuant to  
 HEALTH SERVICES identifying ) Government Code Section  
 items included in or excluded ) 11340.5; Title 1, California  
 from the long term care per ) Code of Regulations,  
 diem rate"<sup>1</sup> ) Chapter 1, Article 3

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Determination by: EDWARD G. HEIDIG, Director

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SYNOPSIS

The issue presented to the Office of Administrative Law ("OAL") is whether twenty-seven administrative bulletins issued between December 24, 1970, and August 5, 1987, concerning the scope of Medi-Cal benefits at Long Term Care facilities, are "regulations" of the Department of Health Services and are therefore without legal effect unless adopted in compliance with the Administrative Procedure Act ("APA").<sup>2</sup>

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OAL has concluded that:

- (1) Eighteen "*challenged bulletins*" are "*regulations*" within the meaning of *Government Code section 11342*.
- (2) Nine bulletins do not implement, interpret and make specific the Medi-Cal law, or govern its procedure, and are not "regulations."

If the Department wishes to exercise its discretion to issue rules governing these topics, it may adopt regulations pursuant to the APA.

### ISSUE

OAL has been requested to determine whether twelve Blue Cross Medi-Cal Bulletins issued from December 24, 1970, to June, 1977, ten Long Term Care Bulletins issued from April 16, 1981, to November, 1986, and five Notices issued by the Department of Health Services from April 4, 1986, to August 5, 1987, concerning the scope of Medi-Cal benefits at Long Term Care facilities, are "regulations" attributable to the Department of Health Services and required to be adopted pursuant to the APA.

### ANALYSIS

#### **I. IS THE APA GENERALLY APPLICABLE TO THE DEPARTMENT OF HEALTH SERVICES' QUASI-LEGISLATIVE ENACTMENTS?**

In 1965, the Medi-Cal program<sup>3</sup> was created by the Legislature as a response to Title XIX of the Social Security Act, which authorized federal financial support to states which adopted conforming medical assistance programs. It was the intent of the Legislature:

*"to provide, to the extent practicable, through the provisions of this [Medi-Cal Act], for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family's future minimum self-maintenance and security."*<sup>4</sup>  
(Emphasis added.)

The program was administered by the State Department of Health and the Department of Benefit Payments. In 1978, as part of an executive branch reorganization, the Department of Health Services was made responsible for the administration of the Medi-Cal program. Welfare and Institutions Code section 10721 provides in part:

"The director [of DHS] shall administer (the Medi-Cal Act) . . . and any other law pertaining to the administration of health care services and medical assistance."

The Director of DHS has been granted general rulemaking authority through Welfare and Institutions Code section 10725. Section 10725 provides in part:

*"The director [of DHS] may adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law enforced by [DHS], and such regulations, orders, and standards shall be adopted, amended, or repealed by the director only in accordance with the [APA] . . . ." (Emphasis added.)*

Welfare and Institutions Code section 14124.5 provides DHS with specific rulemaking authority as it applies to the Medi-Cal program. Section 14124.5 states in part that the:

*"director [of DHS] may . . . adopt, amend or repeal, in accordance with [the APA], such reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of [the Medi-Cal Act] and to enable it to exercise the powers and perform the duties conferred upon it by [the Medi-Cal Act] not inconsistent with any of the provisions of any statute of this state." (Emphasis added.)*

Welfare and Institutions Code sections 10725 and 14124.5, cited above, specifically state that Medi-Cal-related quasi legislative enactments of DHS are subject to the procedural requirements of the APA.

Additionally, the APA applies to *all* state agencies, except those "in the judicial or legislative departments . . ."<sup>5</sup> Since DHS is in neither the judicial nor the legislative branch of state government, OAL concludes that APA rulemaking requirements generally apply to DHS.

The Department administered the Medi-Cal program aided by the Medi-Cal fiscal intermediary, which provided services under a contract with the Department. Blue Cross / Blue Shield, Electronic Data Systems, and Computer Sciences Corporation have, at different times, served as the Medi-Cal fiscal intermediary. The Department obliged the fiscal intermediary to issue bulletins at its direction and upon its behalf to providers as a means of disseminating information deemed important or useful in administering the program. As a consequence, most of the written materials that are alleged to be regulations of the Department were issued by Blue Cross under the Department's authorization, direction, and control.

### **Background; Medi-Cal bulletins and the APA**

In the past, certain rules of the Department contained in various schedules, guidelines, letters and bulletins have been found to be invalid because they were not adopted in accordance with the APA. See *California Association of Nursing Homes, etc. v. Williams* (1970)<sup>6</sup> (changes to Medi-Cal "Schedule of Maximum Allowances" mandated by the Department of Finance); *California Medical Association v. Brian* (1973)<sup>7</sup> ("Medi-Cal consultant guidelines" interpreting and supplementing regulations); *Goleta Valley Community Hospital v. State Department of Health Services* (1983)<sup>8</sup> (agency letter erroneously re-interpreting Medi-Cal hospital reimbursement regulation); and *Planned Parenthood v. Swoap* (1985)<sup>9</sup> (agency statement narrowly interpreting Budget Act provision).

OAL has also reviewed allegedly regulatory matter contained in DHS bulletins. In 1987 OAL Determination No. 10,<sup>10</sup> issued August 6, 1987, OAL analyzed two bulletins and other documents which the Union of American Physicians and Dentists alleged the Department had utilized as regulations in conducting audits of physicians who were Medi-Cal providers. OAL concluded that the bulletins were "regulations" as defined in Government Code section 11342, and therefore are invalid and unenforceable unless adopted in accordance with the Administrative Procedure Act. These same bulletins were later the subject of the decisions in *Grier v. Kizer*, (1990)<sup>11</sup> and *U.A.P.D. v. Kizer* (1990)<sup>12</sup>, in which the Court of Appeal concluded that the bulletins were underground regulations.

## Background of the challenged documents

At the outset, it must be noted that the challenged documents were issued over a period of seventeen years, during which many changes were made in the statutes and regulations governing the Medi-Cal program.<sup>13</sup> The requester alleges that at the time of her request, the Department of Health Services, was utilizing the challenged Blue Cross Medi-Cal Bulletins, Long Term Care Bulletins, and Notices to "define what [is] included in the long term care per diem rate." The Department, in its reply, indicates that any rate issue raised by the documents "became moot long ago as long-term care rates were changed according to the Department's normal procedures and the Administrative Procedure Act . . . when appropriate."

The Department argues that the provider bulletins were simply intended to serve as information of general interest to health care providers and the general public regarding the Department's rules and procedures and "only address material already contained in regulations." The implication is that the Department only issued, utilized or enforced the challenged documents when they were accurate restatements of the applicable law, and did not make use of old bulletins after changes in the statutes or regulations had rendered them obsolete. OAL will answer the request assuming the Department made use of the bulletins from the time they were issued, and afterwards, except to the extent that they were superseded by later ones covering the same subject.

All of the challenged documents are dated. In proceeding to analyze this request for determination, OAL has considered the Medi-Cal law which existed at the time the documents were first issued, and at the time of the request in 1991, but the discussion of the Administrative Procedure Act, and its express prohibition of underground regulations, is based upon current law.

## **II. DO THE "CHALLENGED BULLETINS" CONSTITUTE "REGULATIONS" WITHIN THE MEANING OF GOVERNMENT CODE SECTION 11342?**

The key provision of Government Code section 11342, subdivision (g), defines "regulation" as:

" . . . every rule, regulation, order, or standard of general application

*or* the amendment, supplement, or revision of any such rule, regulation, order or standard adopted by *any* state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure . . . ." (Emphasis added.)

Government Code section 11340.5, authorizing OAL to determine whether agency rules are "regulations," and thus subject to APA adoption requirements, provides in part:

"(a) *No* state agency shall issue, utilize, enforce, or attempt to enforce *any* guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a [']regulation['] as defined in subdivision (g) of Section 11342, *unless* the guideline, criterion, bulletin, manual, instruction, order, standard of general application or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to [the APA]." (Emphasis added.)

In *Grier v. Kizer*,<sup>14</sup> the California Court of Appeal upheld OAL's two-part test<sup>15</sup> as to whether a challenged agency rule is a "regulation" as defined in the key provision of Government Code section 11342, subdivision (g):

First, is the challenged rule either:

- a rule or standard of general application, *or*
- a modification or supplement to such a rule?

Second, has the challenged rule been adopted by the agency to either:

- implement, interpret, or make specific the law enforced or administered by the agency, *or*
- govern the agency's procedure?

If an uncodified rule meets both prongs of the above two parts of the test, OAL must conclude that it is *not* a "regulation" and *not* subject to the APA. In applying

the two-part test, OAL is mindful of the admonition of the *Grier* court:

" . . . because the Legislature adopted the APA to give interested persons the opportunity to provide input on proposed regulatory action (*Armistead, supra*, 22 Cal.3d at p. 204, 149 Cal. Rptr. 1, 583 P.2d 744), we are of the view that *any doubt as to the applicability of the APA's requirements should be resolved in favor of the APA.*" (Emphasis added.)<sup>16</sup>

**A. ARE THE "CHALLENGED BULLETINS" STANDARDS OF GENERAL APPLICATION?**

The "challenged documents" consist of twelve Blue Cross Medi-Cal Bulletins issued from December 24, 1970, to June, 1977; ten Long Term Care Bulletins issued from April 16, 1981, to November, 1986; and five Notices issued by the Department of Health Services from April 4, 1986, to August 5, 1987, concerning the scope of Medi-Cal benefits at Long Term Care facilities. The Blue Cross Medi-Cal Bulletins and Long Term Care Bulletins were published and broadly disseminated to health care providers and the public on a statewide basis. Any standards they may contain were meant to apply to all facilities in a particular class, throughout the state. The 4/4/86 notice to Medi-Cal Providers and the 12/2/86 notice to all Skilled Nursing Facilities were also broadly distributed and intended to apply generally. Two of the documents described generally by OAL as notices in the first sentence above, were evidently issued only to named individuals and are in the form of letters dated 12/2/86 and 1/27/87. Nevertheless, the descriptions in these letters of the addressee's obligations under the Medi-Cal law are evidence of the Department's administration of the law and its application generally to skilled nursing facilities. The final item dated 8/5/87 appears to be an internal memo from the Department's policy division to the eligibility division issued to answer the question of what services and benefits are included in the long term care rate, using laxatives as an example. Even standards in an internal memorandum, when issued and used to guide the agency's application of the law it administers, are standards of general application meant to apply to all of the long-term care facilities in California. Consequently, *OAL concludes the "challenged documents" are standards of general application*; thus satisfying the first element of the two-part test.

**B. DO THE "CHALLENGED BULLETINS" INTERPRET, IMPLEMENT, OR MAKE SPECIFIC THE LAW ENFORCED OR ADMINISTERED BY THE AGENCY OR GOVERN THE AGENCY'S PROCEDURE?**

In order to answer this question for each challenged document, it is necessary to examine them in an orderly fashion. They are presented here in the order in which they were issued. As a consequence, some popular topics are revisited in later documents. OAL review is guided by the requester's interest in the use of bulletins and other notices to identify what is included in the long-term care per diem rate. Materials contained in the bulletins and notices which do not pertain to this subject have not been reviewed by OAL for regulatory matter.

1) Blue Cross Bulletin S-146 was issued by Blue Cross on December 24, 1970, acting in its capacity as the Medi-Cal fiscal intermediary pursuant to a contract with the State Department of Health. Blue Cross acted as the agent of the Department of Health for purposes of administering the Medi-Cal program. Bulletin S-146 is comprised of seven pages of Medi-Cal regulations from Title 22, sections 51056 through 59999, non-inclusive and an ERRATA SHEET for the December 1970 Medi-Cal Drug Formulary. Copies of regulations codified in Title 22 could be distributed by the Department. Under the heading *ERRATA SHEET FOR DECEMBER 1970 MEDI-CAL DRUG FORMULARY* the bulletin contains a five page list of notes describing more than one hundred changes in the listing of drugs and supplies. The original Drug Formulary was filed with the Secretary of State as an emergency regulation on 12/11/70, effective 12/15/70 (Register 70, No.50) and codified in Title 22 as section 59999.

Comparison of the errata sheet and the original formulary reveals that all the changes announced in the errata sheet had already been made by the time section 59999 was filed with the Secretary of State. Evidently the errata sheet in Bulletin S-146 was prepared to correct an earlier draft of the formulary which the Department may have circulated. In any event, the errata sheet makes no changes in the drug formulary which was promulgated in accordance with the APA. Bulletin S 146 is simply a newsletter which did not implement, interpret, or add specificity to the codified regulations.

For long-term care facilities, amendments to the Drug Formulary had no impact upon the level of benefits which they were obliged to provide under the basic rate.

The facilities were obliged to provide drugs included in the formulary and dispensed by licensed pharmacists to their patients, but they could separately bill the Medi-Cal program at the prices included in the formulary, pursuant to Title 22, section 51513.

2) Bulletin S-160 was issued on February 11, 1971, by Blue Cross acting in its capacity as the Medi-Cal fiscal intermediary. It was issued to advise all Medi-Cal Extended Care Facilities:

“that the Medi-Cal Drug Formulary, effective December 14, 1970, no longer lists the following items as payable for Medi-Cal patients in nursing homes:

1. Blood, plasma, and substitutes, including tubing and needles
2. Catheters and other drainage equipment
3. Colostomy or ileostomy supplies
4. Gavage tubing
5. Oxygen”

“This means that claims for the above listed items must be submitted by the individual supplier, (i.e., oxygen by the specific supplier) and billed to California Blue Shield.”

Bulletin S-160 was issued on the date the first amendment to the Medi-Cal Formulary was filed with the Secretary of State. Title 22, section 59999, Part II (Register 71, No.7) lists medical supplies covered by the Medi-Cal Program. Introductory language provides:

“if a beneficiary is in a nursing or convalescent home, only those items marked with a double asterisk (\*\*) are reimbursable, and only when required by a specific patient for his exclusive use.”

Items 1, 2, 3 and 4 in the list above are included in section 59999, Part II and are all marked by a double asterisk. Bulletin S-160 was therefore incorrect with respect to all items except oxygen. The bulletin is in flat contradiction to the applicable law and therefore void, but it is also a standard of general application that purports to be the law. Therefore, the challenged document meets the second part of the test for regulatory content.

3) Blue Cross Bulletin F-98 dated March 19, 1971, was prepared for administrators of all Medicare Extended Care Facilities. It includes a four page Appendix I of Routine Supplies and Services covered in the facility's overall administrative costs, and not separately billable to Medi-Cal. In other words, the Bulletin indicates the cost of the items on this list are covered by the per diem rate paid to the facility by Medi-Cal. Since no statute or lawfully adopted regulation included these provisions, Appendix I made the Medi-Cal law more specific.

Bulletin F-98, Appendix II is a half page list of "Ancillary Supplies and Services," for which an extended care facility could evidently receive additional reimbursement from Medi-Cal. The regulations that came closest to identifying what was separately billable at the time Bulletin F-98 was issued were Title 22, sections 51511 (Register 69, No. 4) and 51513 (Register 68, No. 33). Section 51511 indicated reimbursement to nursing and convalescent homes would be at the rate specified in the State Schedule of Maximum Allowances, Section II, Part C, Long-Term Care Facilities which is in effect at the time medical assistance is provided. Section 51513 indicated that drugs and medical supplies dispensed by licensed pharmacists to nursing home patients would be paid for by the Medical Assistance Program at prices determined in accordance with a formula set forth in the Medi-Cal drug formulary. Comparison of the formulary set forth in Title 22, section 59999 (Register 71, No. 7) and the Appendix II list reveals that not all of the supplies and services included in Appendix II were listed in the formulary. OAL concludes that Bulletin F-98, at the time it was issued, made the Medi-Cal law more specific. Subsequent amendments to section 51511 are discussed below.

4) Bulletin S-224 was issued June 16, 1972, shortly after the rate increase effective 6/1/72. The history of amendments to Title 22, section 51511 suggests that issuance of the bulletin was occasioned by the amendment to that section filed 4/25/72, effective 5/25/72. Only two pages were submitted with the request, but the first page indicates that eight other forms or lists of requirements were included in the mailing. This determination deals only with the two pages submitted for OAL review. The first page contains a disclaimer, as follows:

"The material in this bulletin is advisory only and reflects the Department of Health Care Service's understanding of what is required."

The second page is a one page list entitled CERTAIN SUPPLIES AND APPLIANCES INCLUDED IN NURSING HOME RATES. The list of supplies and appliances included in nursing home rates actually contains lists of items included, and items not included in nursing home rates. Although partly illegible, it is apparent that the list is extensive, containing perhaps 100 entries. The significance of the list is that items which are included in nursing home rates must be furnished by the operator to residents who need them without charge to the residents and without separately billing the Medi-Cal program for their cost. Items not included in the per diem rate, when covered by the program and furnished to residents, could be billed to the program and the operator of the nursing home operator would be reimbursed.

Comparison of the lists in Bulletin S-224 and the lists of equipment and supplies set forth in Title 22, section 51511, subdivision (k) (Register 72, No. 18) reveals that they are the same. Statements in the bulletin concerning the provision of oxygen and related equipment are a correct description of the provisions of section 51511 at the time they were made. Later changes in section 51511 concerning oxygen furnished to Medi-Cal beneficiaries would cause Bulletin S-224 to be superseded. OAL concludes that Bulletin S-224 did not interpret, implement, or make specific the law administered by the Department, or govern its procedure.

5) Medi-Cal Bulletin No. 11 dated March, 1973, describes the billing procedure for inhalation therapy provided in a long-term care or intermediate care facility. It indicates that the services are a benefit of the Medi-Cal Program, but limits the reimbursement to "a cost basis within the established per diem rate for the facility." It also states that "claims submitted by physicians for inhalation therapy services provided to hospital inpatients or patients in long term care or intermediate care facilities are not payable on a fee-for-service basis." OAL has not located any statute or regulation which includes this procedure and prohibition. Bulletin No. 11 implements the Medi-Cal law.

6) Medi-Cal Bulletin No. 48 dated December, 1974, contains the following relevant paragraph:

"This article restates the conditions under which oxygen may be provided to SNF (skilled nursing facility) patients under the Medi-Cal Program. This policy has been effective since June 1, 1972.

“When an SNF patient requires more than the equivalent of one “H” type tank of oxygen per month, additional oxygen may be billed by the oxygen supplier to the MIO [Medi-Cal Intermediary Operations] claims department at Blue Shield when prior authorization has been obtained. The documentation on the TAR [treatment authorization request] submitted to the consultant for approval of additional oxygen must include (a) certification by the facility or oxygen provider that the patient has been supplied with the equivalent of one “H” type tank of oxygen in the month of the request, and (b) verification that the facility has absorbed the cost of this first quantity of oxygen.

“Claims submitted for oxygen provided to SNF patients must be accompanied by an approved TAR or they will not be paid.”

At the time Bulletin No. 48 was issued, Title 22, section 51511, subdivision (l) (Register 74, No. 14) provided that oxygen was one of the supplies that each provider of nursing home services must supply, and that it was included in the per diem rate. Oxygen was not included in section 59998 among the medical supplies covered when prescribed by a licensed practitioner pursuant to section 51320, and the Medi-Cal Formulary (section 59999) treated oxygen as an unlisted drug. Rates for oxygen dispensed in three container sizes were included on the list of charges for Assistive Devices (Durable Medical Equipment) in section 51521, along with Oxygen Therapy Equipment. In any event, the rule announced in Bulletin No. 48 limiting the oxygen requirement under section 51511, subdivision (l), to one “H” type tank per month per patient is a policy not to be found in the codified regulations. Therefore it interprets the Medi-Cal law administered by the Department.

7. Medi-Cal Bulletin 49 issued in December, 1974, contains two pertinent rules. It states that cervical pillows and sodium salicylate are not benefits of the Medi-Cal Program. Concerning sodium salicylate, it continues: “[n]onlegend analgesics such as sodium salicylate are included in the items that must be supplied by the facility (SNF) to its patients . . . .” The rule on sodium salicylate comes directly from Title 22, section 51511, subdivision (l) (Register 74, No.14), without change or interpretation. It is not a regulation.

Cervical pillows are not mentioned in any regulation by name, but section 51511 includes “beds, mattresses, . . . and other equipment and supplies commonly used

in providing nursing home care” among the items nursing homes must provide because they are covered by the per diem rate. Cervical pillows are distinguishable from the bedding items mentioned, and the “other equipment and supplies commonly used” category included in the regulation is imprecise. OAL must conclude that the rule on cervical pillows is an interpretation of the law.

8. A bulletin issued under the heading “Medi-Cal Intermediary Operations” and dated August, 1975, announces amendments to Title 22, sections 51510 and 51511. It contains new rates for intermediate care facilities and skilled nursing facilities operative August 1, 1975, and the lists of supplies and equipment included and not included in the rates for intermediate care facilities and skilled nursing facilities. Following the lists of supplies and equipment, there is a note which advises the facility operators that oxygen is no longer included in the list of supplies and equipment a facility must provide within its daily reimbursement rate.

This bulletin coincides with the emergency amendment to section 51511 filed and effective 8/1/75 (Register 75, No. 31). The rates and lists of equipment and supplies included and not included are identical to those set forth in sections 51510 and 51511, and are presented without any interpretation by the Department. Oxygen was deleted from the list of equipment and supplies which must be provided within the daily reimbursement rate effective 7/16/76 (Register 75, No. 29). An amendment to the Medi-Cal formulary (Title 22, section 59999) effective 6/29/75 (Register 75, No. 22) added oxygen to the alphabetical list of drugs covered under Sections 51313 and 51413 and payable under 51513 at rates specified in section 51521. These sections applied to out of hospital and nursing home patients. Therefore, it is clear that under the regulations in effect when the bulletin was issued in August, 1975, the advisory concerning oxygen was a statement of the law, without interpretation.

9. Medi-Cal Bulletin No. 59 issued in August, 1975, reminds providers of the provisions of Title 22, section 51335, subdivision (g), concerning the need for a signed order of the physician responsible for the care of a patient in order for services to be provided under the Medi-Cal Program. This reminder does not involve any interpretation of section 51335. It also states a rule for mileage charges for medical transportation.

“Charges for ground medical transportation may be billed to the

Medi-Cal Program from the point of patient pickup to the point of delivery only. No mileage charge may be made for any distance travelled by an empty ambulance.”

Title 22, section 51323 (Register 72, No. 40) entitled *Medical Transportation Services* was effective at the time Bulletin No. 59 was issued. It does not cover the subject of measurement of mileage. OAL has been unable to locate any codified rule which included the substance of this provision. Therefore, OAL concludes that the mileage rule is an interpretation of the Medi-Cal law.

10. Medi-Cal Bulletin No. 69 issued in February, 1976, contains the lists of equipment and supplies included and not included in the rates for intermediate care beneficiaries. The bulletin describes the lists as effective July 15, 1975. In February, 1976, the most recent versions of the lists of equipment and supplies were as set forth in sections 51510 and 51511, effective August 1, 1975 (Register 75, No. 31), the same lists discussed in paragraph 8 above. Nevertheless, the bulletin is correct in its description of the lists' effective date because the August 1, 1975, amendments affected only the rates, and not the lists. The equipment and supplies on the lists in Bulletin No. 69 are identical to the requirements in the regulations which were in effect at the time.

Bulletin No. 69 also reminds providers of skilled nursing and intermediate care levels of service that laxatives are included in the Medi-Cal per diem rate. This is a correct restatement of a portion of section 51510, subdivision (b), and section 51511, subdivision (b), without interpretation.

11. Medi-Cal Bulletin No. 74, issued in May, 1976, is a seven page document, of which very little is specific to skilled nursing or intermediate care facilities. It repeats the admonition that sodium salicylate is not payable for skilled nursing facility or intermediate care facility patients. This is correct, as required by section 51510, subdivision (b) (Register 76, No.13), and section 51511, subdivision (b) (Register 76, No.13), and discussed in paragraph 7 above. It further states that sodium chloride irrigating solution is not separately payable for SNF/ICF patients, and cites Bulletin No. 52<sup>17</sup> as a reference. OAL is unable to locate any provision of law which established such a rule. Sections 51510 and 51511 (Register 76, No.13) did require irrigating standards and irrigating cans to be furnished by skilled nursing and intermediate care facilities within the per diem rate, but irrigating solutions were not mentioned. Therefore, the rule prohibiting

billing for sodium chloride irrigating solution is an interpretation of other Medi-Cal laws.

Bulletin No. 74 also includes a paragraph on oxygen for skilled nursing facility patients. Its provisions are equivalent to the bulletin discussed in paragraph 8 above, and the applicable law and analysis in May of 1976 are identical to the situation in August, 1975. The discussion of oxygen is therefore not an interpretation of the Medi-Cal law.

12. Bulletin 88B, dated June, 1977, is mostly a reprint of amendments to the Medi-Cal formulary effective 6/25/77. In connection with the changes in the formulary, it also describes nutritional supplements as a new benefit of the program, subject to prior authorization. After discussion of the medical conditions which indicate the need for such supplements, and examples of each, the bulletin continues:

“Providers should note that nutritional supplements or replacements are not separately payable for skilled nursing facility (SNF) or intermediate care facility (ICF) patients since provisions for these items are included in the SNF/ICF per diem rates.”

The lists of supplies and equipment which are included in the per diem rate set forth in sections 51510 and 51511 were not amended to include this provision on nutritional supplements. OAL has not been able to locate a similar provision in another regulation, and therefore must conclude that the rule on payment for nutritional supplements in SNFs and ICFs interprets the Medi-Cal law.

13. One page from Long-Term Care Bulletin No. 14, issued 4/16/81, was presented for OAL review. The only relevant provision is the following, under the heading *Op Site T Gauze Bandaging*:

“Op Site T gauze bandaging, manufactured by Acme-United, *is not separately payable* for patients in Skilled Nursing Facilities or Intermediate Care Facilities. Since gauze bandaging is considered part of a facility’s per diem rate, Treatment Authorization Requests for inpatient use of Op Site T will not be approved by Medi-Cal Consultants.” (Emphasis added.)

This rule is a restatement of the only possible meaning of Title 22, section 51510, subdivision (b) (Register 80, No. 52) and section 51511, subdivision (b) (Register 80, No. 52), both of which state that each provider shall furnish gauze dressing under the basic per diem rate. Therefore, it does not interpret the Medi-Cal law.

14. Allied Health Services Bulletin No. 71, issued in July, 1984, contains a list of 34 items of Durable Medical Equipment and, in an adjacent column, an indication of whether each is included in the skilled nursing facility / intermediate care facility per diem rates, or is separately billable and reimbursable, subject to prior authorization. For the most part, the list followed the provisions of Title 22, sections 51510 and 51511 (Register 83, No.52), and section 59999 (Register 84, No. 24). Items identified by OAL as interpretations of the Medi-Cal law include the listing of the dry heating pad, electric breast pump, and breast pump kit. The bulletin indicates these items are not within the scope of benefits and implies that they are included in the SNF / ICF per diem rate. Because these items are not found in the codified regulations, the bulletin excluding them from the scope of benefits makes the Medi-Cal law more specific.

15. Long Term Care Bulletin No. 72, issued in March, 1985, announced a new law relating to laundry and haircuts in long term care facilities.

“[E]ffective February 1, 1985, all types of skilled nursing facilities and intermediate care facilities must provide laundry services and periodic hair trims to Medi-Cal patients at no charge to the patient. Required laundry services now include laundering patient-owned apparel. The facility may, however, charge the patient for the following:

“Special dry cleaning or treatment for a garment needing this care, when the garment is owned by the patient and when the regular laundry service is not appropriate

“Beauty shop services for patients who request special treatments or styling of their hair.”

Bulletin No. 72's information on laundry and haircuts is the only legally tenable interpretation of Welfare and Institutions Code section 14110.4, subdivisions (a), and (b), effective 1/1/85; Title 22, section 51510, subdivision (d) (Register 85, No.

12), effective 2/1/85; and section 51511, subdivision (d) (Register 85, No. 12), effective 2/1/85. Therefore, the bulletin does not interpret the Medi-Cal law.

16. Long Term Care Bulletin No. 75, issued April, 1985, announces changes in procedure made necessary by a court order issued March 22, 1985, in the case of *Johnson v. Rank*, effective May 1, 1985. The procedure announced in the bulletin was intended to allow Medi-Cal beneficiaries residing in long term care facilities who were obliged to pay a share of the cost of their care to deduct from the share of cost they were obliged to pay to the facility, the amount of money they had expended in the prior month for necessary noncovered medical services. The procedure required providers to collect money from beneficiaries to cover their share of cost in advance, submit specified forms to the Department, and pay for beneficiaries' noncovered medical and remedial services upon receipt of billing. The bulletin was a standard of general application issued by the Department to govern its procedure.<sup>18</sup>

17. A bulletin entitled *UPDATED INFORMATION* dated August, 1985, announced a new procedure, effective May, 1985, for implementing the *Johnson v. Rank* decision. It was similar to the procedure discussed in paragraph (16) above, but included a modification identified as "full month rollover" to allow beneficiaries additional time to submit bills for necessary but noncovered services to their long term care facilities. As before, this new procedure was not included in any codified regulation. This bulletin also included the list of services included in the long term care daily facility payment rate, identifying the source as Title 22, section 51511. The list is the same as the regulation (Register 85, No. 23) which was then current. Therefore, the list of services included in the long term care per diem rate is simply a restatement of the law. The bulletin's modified rule on full month rollover, however, is a standard of general application that governs the Department's procedure.

18. One page from Long-Term Care Bulletin No. 87, issued in February, 1986, was presented for OAL review. It contains two items of interest. Under the heading *Patient Plans of Care Required*, the bulletin provides:

"Institutional providers such as acute care hospitals, psychiatric hospitals, skilled nursing facilities, and intermediate care facilities, must include a written Plan of Care in each patient's medical record. Manual replacement pages reflecting this new policy are included

with this bulletin.”

At the time Bulletin No. 87 was issued Title 22, section 72311, subdivision (a)(1)(B) (Register 83, No. 7) required a written plan of care for each patient in a skilled nursing facility, and specified the requisite contents of such plans. Similarly, section 73311, subdivision (a) (Register 75, No. 24) required a written plan of care for each patient in a intermediate care facility. These regulations were contained in the health facility licensing regulations rather than the Medi-Cal regulations, but clearly did apply to these long term facilities without regard to whether they were caring for Medi-Cal patients. Therefore, the bulletin’s article on patient plans of care simply provided information deemed useful, and was not a standard of general application issued to interpret the law.

Under the heading *Reminder: Supplies Are Included in LTC Per Diem Rates*, the bulletin provides:

“All items of equipment and supplies commonly used in providing nursing care in long term care (LTC) facilities are *included in the per diem rate* and are not separately payable by either Medi-Cal or the beneficiary. Examples of such items include incontinence supplies (diapers, disposable underpads, and liners, incontinence pants, cellucotton, etc.), sanitary pads, hospital-type gowns, bedding and pillows.” (Emphasis added.)

Title 22, section 51510, subdivision (b) (Register 85, No. 52) lists a large number of specific items of equipment and supplies that intermediate care facilities must furnish as well as the general requirement to furnish commonly used items, as follows:

“Notwithstanding any other provisions of these regulations, each provider of intermediate care services shall furnish the following equipment and supplies:

“Canes, crutches, wheelchairs, walkers, autoclaves, sterilizers, *beds, mattresses*, bed rails, footboards, cradles, trapeze bars, patient lifts, scissors, forceps, nail files, weighing scales, icebags, flashlights, all equipment (other than nasal catheters and positive pressure apparatus) necessary for the administration of oxygen, nonlegend

analgesics and laxatives, lubricants, rubbing compounds, antiseptics, first aid supplies (such as alcohol, merthiolate, bandages, etc.), hypodermic syringes and needles, rubber goods such as rectal tubes, catheters, gavage tubing, soft restraints, *incontinence pads*, urine bags, colostomy or ileostomy pouches and accessories, gauze dressings, thermometers, tongue depressors, applicators, bedside utensils (such as bedpans, basins, irrigating cans and drinking tubes), charting supplies *and other equipment and supplies commonly used in providing intermediate care services.*” (Emphasis added.)

The first sentence from the *Reminder* above is simply a restatement of the closing phrase of subdivision (b), without interpretation. The alleged underground regulations are the five items listed as examples in the second sentence: “. . . *incontinence supplies* (diapers, disposable underpads, and liners, incontinence pants, cellucotton, etc.), *sanitary pads, hospital-type gowns, bedding and pillows.*” (Emphasis added.) The CCR provision lists “beds” and “mattresses.” OAL concludes that “bedding” and “pillows” are so closely related to “beds” and “mattresses,” and so obviously items “commonly used in providing intermediate care services,” that requiring them does not constitute an underground regulation.

Similarly, the Bulletin’s list of incontinence supplies is either identical to or closely related to the CCR provision’s “incontinence pads” item.<sup>19</sup> This part of the bulletin is not an underground regulation.

On the other hand, it is more difficult to link up “hospital-type gowns” and “sanitary pads” to items specifically listed in the CCR provision. Though it is a close question, OAL concludes that requiring these two items has the effect of “making specific” the phrase “commonly used” items, and thus violates the APA. Because the CCR provision contains such a long list of *specific* items, it seems unreasonable to permit that list to be expanded through the issuance of bulletins, rather than amended formally through the rulemaking process.

19. Long Term Care Bulletin No. 89, issued in April, 1986, followed and amended Bulletin No. 75, and its Update, discussed in paragraphs 16 and 17 above. In April, 1985, Bulletin No. 75, had established procedures to allow Medi-Cal beneficiaries residing in long term care facilities who were obliged to pay a share of the cost of their care to deduct from the share of cost they were obliged to pay to the facility, the amount of money they had expended in the prior month for

necessary noncovered medical services. The August, 1985, Update of Bulletin No. 75 allowed beneficiaries more time to submit their bills for necessary noncovered medical services, but, like Bulletin No. 75, required the beneficiaries to pay their full share of cost to their long term care facility at the beginning of each month, receiving their reimbursement in arrears.

Bulletin No. 89 advised providers of a new option for beneficiaries, allowing them to pay the share of cost or a portion of it by submitting to the provider receipts for necessary noncovered medical services, rather than money. As was true in the two prior attempts to implement the court's order in *Johnson v. Rank*, this new rule was not included in any codified regulation. It is a standard of general application that was issued to govern the Department's procedure.

20. The Department of Health Services issued a Notice to Medi-Cal beneficiaries residing in long term care facilities on April 4, 1986. This Notice advised beneficiaries of the new optional method for paying their share of cost using receipts for necessary noncovered medical services. The procedure is described in Bulletin No. 89, which was concurrently issued and is discussed in paragraph 19 above. Although Bulletin No. 89 and the Notice are separate documents, the payment procedure they prescribe is the same standard of general application. Therefore, it is a standard of general application that was issued to govern the Department's procedure.

21. One page from Long-Term Care Bulletin No. 97, issued in September, 1986, was presented for OAL review. It contains the following standard of interest, identified as an *Update to Inclusive and Exclusive Items List*:

“Note that incontinence supplies and irrigating solutions are included in the Long Term Care per diem rate and may not be billed separately.”

The note is followed by the advice that the “bulletin includes a revised manual page adding these supplies to the Inclusive and Exclusive items List.” Bulletin 97's recitation of the standard for incontinence supplies is no different from that in Bulletin 87, discussed in paragraph 18 above. It does not interpret the Medi-Cal law.

The Bulletin's inclusion of irrigating solutions in the long term care per diem rate

was not based upon sections 51510 and 51511 (Register 85, No. 52) and does not correspond with any other codified regulation in existence at the time. The discussion of Bulletin 74's rule on sodium chloride irrigating solution in paragraph 11 above applies equally to irrigating solutions generally, as mentioned in Bulletin No. 97. The new manual page was used by the Department to add irrigating solutions to the *Inclusive Items List*, making the Medi-Cal law more specific.

22. One page from Long-Term Care Bulletin No. 98, issued in October, 1986, was presented for OAL review. Under the heading *Clarification of Haircut Requirement*, it includes a discussion of some of the provisions of Welfare and Institutions Code section 14110.4. It goes on to describe the proper apportionment of charges in instances where a beneficiary receives a free hair trim and shampoo at the same time other beauty shop services not covered in the per diem rate are provided. The apportionment described in the bulletin is the only legally tenable application of Welfare and Institutions Code section 14110.4, subdivision (b), which describes the periodic hair trim requirement; and Title 22, section 51510, subdivision (d) (Register 86, No. 32); section 51511, subdivision (d) (Register 86, No. 32); and section 59998, subdivision (a)(7) (Register 83, No. 7) to the hypothetical example presented in the bulletin.

23. One page from Long-Term Care Bulletin No. 99, issued in November, 1986, was presented for OAL review. The only relevant item included in this bulletin is described as a clarification of the "*Inclusive and Exclusive Items List* published in Long Term Care No. 98 (October 1986)." Although OAL examined one page from Bulletin No. 98 in paragraph 22 above, the list was not included. OAL did, however, consider the *Inclusive and Exclusive Items List* in paragraph 21 above. The only change made by Bulletin No. 99 is to add the words "sodium chloride" before "irrigating solutions" as an item on the inclusive portion of the list. As noted in paragraphs 11 and 21 of this determination, the listing of this item as included in the per diem rate of long term care facilities interprets the Medi-Cal law.

24. A three page letter from the Department's Deputy Director of Medical Care Services to all SNFs and ICFs dated 12/2/86 attempted to resolve several problems that had become apparent in implementing the provisions of the *Johnson v. Rank* decision. It repeated several standards already analyzed in paragraphs 16, 17, 19 and 20 above. It also announced an apparently new requirement:

“The long-term care (LTC) facility is required to maintain documentation within the patient’s medical record on forms provided by the Department to assure that this process [assuring that the noncovered medical services purchased by beneficiaries and set off against their share of cost are consistent with the plan of care ordered by a physician] occurs.” . . .

“Documentation of the necessity for any service or supply used to meet the SOC (either uncovered or covered) is required before a purchase is justified under Johnson.”

The requirement for a plan of care is discussed in paragraph (18) above. The additional requirements for maintenance of records and documentation on forms provided by the Department is a standard, or measure generally applicable to long term care facility operators implementing the Medi-Cal law. The letter also repudiated an earlier guideline published in Computer Sciences Corporation’s<sup>20</sup> August, 1985, Provider Bulletin and All County Welfare Directors Letter 85-59. The earlier guideline, which had been adopted to provide uniformity in the use of Treatment Authorization Requests, was replaced by a new guideline announced in this letter, which also relies upon the Computer Sciences Corporation’s Provider Manual. The December 2, 1986, letter’s new guideline was utilized to implement, interpret, and make specific Medi-Cal law and procedures.

25. A letter from the Department’s Los Angeles Field Office to Care Medical Mart dated December 2, 1986, attempts to identify types of durable medical equipment not separately payable for long term care beneficiaries. It states:

“According to Program Coverage Section 51321, Medi-Cal Benefit Chart, the following items are not separately payable for skilled nursing facility (SNF) / intermediate care facility (ICF) inpatients:

- Waterbeds
- Therapeutic Mattresses (Orthopedic)

“According to program history, the following items are not separately payable for SNF / ICF inpatients:

- DecubiCare Wheelchairs

- Posture Support Wheelchairs
- OrthoSupport Wheelchairs
- Geriatric Chairs
- MultiCare Chairs”

The exclusion of waterbeds and orthopedic mattresses is correct, as required by Title 22, section 51321, subdivision (e) (Register 86, No.45), which specifically provides that orthopedic mattresses and waterbeds are not covered by the Medi-Cal program. As for wheelchairs and other specialized chairs, it appears that the provisions of section 51510, subdivisions (b), and (c) (Register 86, No. 49) and section 51511, subdivisions (b), and (c) (Register 86, No. 49) require the conclusion announced in the letter. Wheelchairs and other physician-prescribed durable medical equipment are not separately billable unless they must be custom made or modified to meet the unusual medical needs of a patient. Therefore, the Department’s letter to Care Medical Mart does not provide further interpretation of the Medi-Cal law.

26. A letter from the Department to the Casa Bonita Convalescent Hospital dated January 27, 1987, explains that nutritional supplements are a benefit of the Medi-Cal Program.

“The Medi-Cal program provides for all nutritional needs of Medi-Cal patients in nursing homes by accounting for this in the per diem rates paid to facilities.”

The letter points out that under the skilled nursing facility licensing regulations, Title 22, section 72339, nursing facilities are required to provide therapeutic diets for their patients. The letter continues, noting that Title 22, section 51483, prohibits providers from seeking payment from a Medi-Cal beneficiary or from other persons on behalf of a beneficiary for any service included in the Medi-Cal scope of benefits, and concludes by advising the convalescent hospital that the cost of nutritional supplements cannot be used to reduce a patient’s share of cost under *Johnson v. Rank*.

Section 51483 (Register 86, No. 49) actually prohibited providers who failed to meet licensing standards from participating in the Medi-Cal program. It is not helpful in resolving the question of whether nutritional supplements were included in the per diem rate. The other regulation mentioned in the letter, section

72339 (Register 82, No. 8), provided as follows:

“Therapeutic diets shall be provided for each patient as prescribed and shall be planned, prepared and served with supervision and / or consultation from the dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food values to make appropriate substitutions when necessary.”

Section 73339 is one paragraph in five pages of regulations on dietetic service at skilled nursing facilities. Nowhere in these regulations was there any mention of nutritional supplements. The dietetic regulations specified requirements relating to meal planning, recipes, variety, patient preferences, table service, food storage, sanitation, equipment, supplies, and milk. Concerning therapeutic diets, section 72335, subdivision (a)(7) (Register 82, No. 8) provided:

“Recipes for all items that are prepared for . . . therapeutic diets shall be available and used to prepare attractive and palatable meals, in which nutritive values, flavor and appearance are conserved. Food shall be served attractively, at appropriate temperatures with appropriate eating utensils and in a form to meet individual needs.”

It is abundantly clear that packaged nutritional supplements were not contemplated as the means of delivering a therapeutic diet. Certainly the requirement for therapeutic diets does not clearly answer the question of who must pay for nutritional supplements prescribed for patients who are Medi-Cal beneficiaries. Mindful of the fact that any doubt as to the applicability of the APA should be resolved in favor of an agency's following APA rulemaking procedures, OAL concludes that the Department's letter to the Casa Bonita Convalescent Hospital interprets the Medi-Cal law.

27. The last challenged document is a memorandum from the chief of the Medi-Cal Benefits Branch to the Chief of the Medi-Cal Eligibility Branch, dated August 5, 1987. The memorandum was written to answer three questions about supplies included in the long term care per diem rate that had been posed by the Chief of the Eligibility Branch. The questions had been presented using an example, with a ruling and rationale requested. It was agreed that section 51510, subdivision (b) (Register 87, No. 33) and section 51511, subdivision (b) (Register 87, No. 33) clearly require ICFs and SNFs to furnish laxatives needed by their patients.

- (1) The first question was whether the facility was obliged to furnish more than one kind or brand of laxative. The chief of benefits answered that any laxative appropriate to the patient's need "is included" in the per diem rate.
- (2) The second question was whether, when a physician specifically orders a name brand laxative different from the one supplied by the facility, the name brand laxative would be a noncovered service which could be deducted from a patient's share of cost. The answer was that the per diem rate covers any laxative that meets the needs of the patient.
- (3) The third question was whether a doctor's order is sufficient to demonstrate the "medical necessity" of prescribing a brand of laxative other than the brand supplied by the facility as part of the per diem rate. The answer was that all laxatives are covered in the per diem rate, and that nursing home administrators should negotiate with physicians as to the necessity of using a brand other than the house brand.

The answers provided by the Chief of the Medi-Cal Benefits Branch are a reasonable application of the regulations, rather than interpretations establishing new law. The regulations stated that laxatives are included, and the Chief followed that rule. Although it might be reasonable to create, by regulation, an exception for prescribed laxatives more costly than the one generally supplied by a facility, no such exemption existed in the regulations. The memorandum from the chief of the Medi-Cal Benefits Branch did not implement any new standards of general application or govern the Department's procedures.

Thus, 18 "*challenged bulletins*" not only contain standards of general application, they also *implement, interpret, and make specific the laws enforced by the Department*. Both elements of the two-part test have been satisfied for these documents. *OAL concludes that 18 "challenged bulletins" contain "regulations" within the meaning of Government Code section 11342.* The other 9 bulletins do not implement, interpret and make specific the Medi-Cal law, or govern its procedure, and are not regulations.

### **III. DO ANY OF THE "CHALLENGED BULLETINS" FOUND TO CONTAIN "REGULATIONS" FALL WITHIN ANY *SPECIAL***

## EXPRESS STATUTORY EXEMPTION FROM APA REQUIREMENTS?<sup>21</sup>

In its response, the Department does not contend that any special exemption applies. OAL concurs. *No exemption applies to the "challenged sections" now, or at the time the request was filed.*

### IV. DO ANY OF THE "CHALLENGED BULLETINS" FOUND TO CONTAIN "REGULATIONS" FALL WITHIN ANY GENERAL EXPRESS STATUTORY EXEMPTION FROM APA REQUIREMENTS?

Generally, all "regulations" issued by state agencies are required to be adopted pursuant to the APA, unless *expressly* exempted by statute.<sup>22</sup> Rules concerning certain specified activities of state agencies are not subject to the procedural requirements of the APA.<sup>23</sup>

### INTERNAL MANAGEMENT

Government Code section 11342, subdivision (g), expressly exempts rules concerning the "internal management" of *individual* state agencies from APA rulemaking requirements:

"Regulation' means every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure, *except one that relates only to the internal management of the state agency.*" (Emphasis added.)

*Grier v. Kizer* provides a good summary of case law on internal management. After quoting Government Code section 11342, subdivision (b), the *Grier* court states:

"*Armistead v. State Personnel Board* [citation] determined that an agency rule relating to an employee's withdrawal of his resignation did not fall

within the internal management exception. The Supreme Court reasoned the rule was 'designed for use by personnel officers and their colleagues in the various state agencies throughout the state. It interprets and implements [a board rule]. It concerns termination of employment, a matter of import to all state civil service employees. It is not a rule governing the board's internal affairs. [Citation.] 'Respondents have confused the internal rules which may govern the department's procedure . . . and *the rules necessary to properly consider the interests of all . . . under the statutes. . . .*' [Fn. omitted.] . . . [Citation; emphasis added by *Grier* court.]

"*Armistead* cited *Poschman v. Dumke* [citation], which similarly rejected a contention that a regulation related only to internal management. The *Poschman* court held: 'Tenure within any school system is a matter of serious consequence involving an important public interest. The consequences are not solely confined to school administration or affect only the academic community.' . . . [Citation.][<sup>24</sup>]

"Relying on *Armistead*, and consistent therewith, *Stoneham v. Rushen* [citation] held the Department of Corrections' adoption of a numerical classification system to determine an inmate's proper level of security and place of confinement 'extend[ed] well beyond matters relating solely to the management of the internal affairs of the agency itself[,] and embodied 'a rule of general application significantly affecting the male prison population' in its custody. . . .

"By way of examples, the above mentioned cases disclose that the scope of the internal management exception is narrow indeed. This is underscored by *Armistead's* holding that an agency's personnel policy was a regulation because it affected employee interests. Accordingly, even internal administrative matters do not per se fall within the internal management exception. . . ." <sup>25</sup>

*OAL concludes that none of the 18 challenged bulletins found to be standards of general application adopted by the Department to implement, interpret, or make specific the Medi-Cal law or govern its procedure fall within any general express statutory exemption from the requirements of the APA. Therefore, OAL concludes that 18 challenged bulletins contain "regulations" within the meaning of Government Code section 11342, subdivision (g). OAL concludes these bulletins*

and other documents were without legal effect since their regulatory provisions had not been adopted in compliance with the APA.

*Since the 18 bulletins and other documents identified as containing standards of general application that interpret, implement, or make specific the Medi-Cal law or govern the Department's procedure do not fall within any special express statutory exemption or any general express statutory exemption from the requirements of the APA, and have not been adopted in compliance with the requirements of the APA, they have no legal effect.<sup>26</sup>*

## CONCLUSION

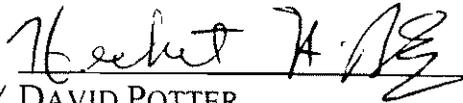
For the reasons set forth above, OAL finds that:

- (1) Eighteen of the "challenged bulletins" are "regulatory," and do not fall within any exemption to the APA. Therefore, they were without legal effect.
- (2) Nine of the challenged bulletins and other documents are not "regulations."

DATE: September 23, 1998



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## ENDNOTES

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1. This request for Determination was filed by Diane S. Campbell, an attorney. The Department of Health Services was represented by J. Douglas Porter, Deputy Director Medical Care Services, 714/744 P Street, P.O. Box 942732, Sacramento, CA 94234-7320.
2. According to Government Code section 11370:

*"Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) constitute, and may be cited as, the Administrative Procedure Act."* [Emphasis added.]

*OAL refers to the portion of the APA which concerns rulemaking by state agencies: Chapter 3.5 of Part 1 ("Administrative Regulations and Rulemaking") of Division 3 of Title 2 of the Government Code, sections 11340 through 11359.*
3. Medi-Cal Act (chapter 7, part 3, division 9, of the Welfare and Institutions Code, sections 14000 - 14196.1).
4. Welfare and Institutions Code section 14000.
5. Government Code section 11342(a). See Government Code sections 11343 and 11346. See also 27 Ops.Cal.Atty.Gen. 56, 59 (1956).
6. 4 Cal.App.3d 800, 84 Cal.Rptr. 590.
7. 30 Cal.App.3d 637, 106 Cal.Rptr. 555.
8. 149 Cal.App.3d 1124, 197 Cal.Rptr. 294.
9. 173 Cal.App.3d 1187, 219 Cal.Rptr. 664.
10. 1987 OAL Determination No. 10 (Department of Health Services, August 6, 1987, Docket No. 86-016), summary published in CANR 87, No. 34-Z, August 21, 1987, p.63; complete determination published on February 23, 1996, CRNR 96, No. 8-Z, p.292.
11. 219 CalApp.3d 422, 268 Cal Rptr. 244.
12. 223 CA3d 490, 272 Cal Rptr. 886.

13. The codified regulations of the Department for administration of the Medi-Cal program are found in California Code of Regulations, Title 22, Division 3, beginning with section 50000. Unless otherwise specified, all references to section numbers in this determination refer to Title 22.
14. (1990) 219 Cal.App.3d 422, 440, 268 Cal.Rptr. 244, 251. We note that a 1996 California Supreme Court case stated that it “disapproved” of *Grier* in part. *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 577. *Grier*, however, is still good law, except as specified by the *Tidewater* court. Courts may cite cases which have been disapproved on other grounds. For instance, in *Doe v. Wilson* (1997) 57 Cal.App.4th 296, 67 Cal.Rptr.2d 187, 197, the California Court of Appeal, First District, Division 5 cited *Poschman v. Dumke* (1973) 31 Cal.App.3d 932, 107 Cal.Rptr. 596, on one point, even though *Poschman* had been expressly disapproved on another point nineteen years earlier by the California Supreme Court in *Armistead v. State Personnel Board* (1978) 22 Cal.3d 198, 204 n. 3, 149 Cal.Rptr. 1, 3 n. 3. Similarly, in *Economic Empowerment Foundation v. Quackenbush* (1997) 57 Cal.App.4th 677, 67 Cal.Rptr.2d 323, 332, the California Court of Appeal, First District, Division 4, nine months after *Tidewater*, cited *Grier v. Kizer* as a distinguishable case on the issue of the futility exception to the exhaustion of administrative remedies requirement.

*Tidewater* itself, in discussing which agency rules are subject to the APA, referred to “the two-part test of the Office of Administrative Law,” citing *Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 497, 272 Cal.Rptr. 886, a case which quotes the test from *Grier v. Kizer*.

15. The *Grier* Court stated:

“The OAL’s analysis set forth a two-part test: ‘First, is the informal rule either a rule or standard of general application or a modification or supplement to such a rule? [Para.] Second, does the informal rule either implement, interpret, or make specific the law enforced by the agency or govern the agency’s procedure?’ (1987 OAL Determination No. 10, *supra*, slip op’n., at p. 8.)

OAL’s wording of the two-part test, drawn from Government Code section 11342, has been modified slightly over the years. The cited OAL opinion--1987 OAL Determination No. 10--was published after *Grier*, in California Regulatory Notice Register 98, No. 8-Z, February 23, 1996, p. 292.

16. (1990) 219 Cal.App.3d 422, 438, 268 Cal.Rptr. 244, 253.
17. Bulletin No. 52 dated February, 1975, was not one of the documents submitted by the requester for OAL review.

18. An agency may issue a bulletin announcing a legally binding judicial interpretation of a statute without exercising quasi-legislative power. If the agency limits the standards prescribed in its bulletin and their application to the requirements of the court, it has not engaged in rulemaking. The Department, although clearly motivated by the order issued in the *Johnson v. Rank* litigation, was evidently the author of the three attempts to implement a satisfactory new procedure. Moreover, the Department did not provide a copy of this order in its response or argue that Bulletin No. 75 was simply a restatement of that order.
19. Title 22, section 51510, subdivision (d) (Register 85, No. 52) and section 51511, subdivision (d) (Register 85, No. 52).
20. Computer Sciences Corporation had performed the services of the Medi-Cal intermediary under a contract with the Department of Health Services.
21. All state agency "regulations" are subject to the APA unless expressly exempted by statute. Government Code section 11346. Express statutory APA exemptions may be divided into two categories: special and general. Cf. *Winzler & Kelly v. Department of Industrial Relations* (1981) 121 Cal.App.3d 120,126, 174 Cal.Rptr. 744, 747 (exemptions found either in prevailing wage statute or in the APA itself). *Special* express statutory exemptions, such as Penal Code section 5058, subdivision (d)(1), which exempts Corrections' pilot programs under specified conditions, typically: (1) apply only to a portion of one agency's "regulations" and (2) are found in that agency's enabling act. *General* express statutory exemptions, such as Government Code section 11342, subdivision (g), part of which exempts internal management regulations from the APA, typically apply across the board to all state agencies and are found in the APA.
22. Government Code section 11346.
23. The following provisions of law may permit rulemaking agencies to avoid the APA's requirements under some circumstances:
  - a. Rules relating *only* to the internal management of the state agency. (Gov. Code, sec. 11342, subd. (g).)
  - b. Forms prescribed by a state agency or any instructions relating to the use of the form, *except* where a regulation is required to implement the law under which the form is issued. (Gov. Code, sec.11342, subd. (g).)
  - c. Rules that "[establish] or [fix], rates, prices, or tariffs." (Gov. Code, sec. 11343, subd. (a)(1).)
  - d. Rules directed to a *specifically named* person or group of persons *and* which do not apply generally throughout the state. (Gov. Code, sec. 11343, subd. (a)(3).)

- e. Legal rulings *of counsel* issued by the Franchise Tax Board or the State Board of Equalization. (Gov. Code, sec. 11342. subd. (g).)
  - f. There is weak authority for the proposition that contractual provisions previously agreed to by the complaining party may be exempt from the APA. *City of San Joaquin v. State Board of Equalization* (1970) 9 Cal.App.3d 365, 376, 88 Cal.Rptr. 12, 20 (sales tax allocation method was part of a contract which plaintiff had signed without protest). The most complete OAL analysis of the "contract defense" may be found in 1991 OAL Determination No. 6, pp. 175-177. Like *Grier v. Kizer* (1990) 219 Cal.App.3d 422, 268 Cal.Rptr. 244, **1990 OAL Determination No. 6** (Department of Education, Child Development Division, March 20, 1990, Docket No. 89-012), California Regulatory Notice Register 90, No. 13-Z, March 30, 1990, p. 496, rejected the idea that *City of San Joaquin* (cited above) was still good law.
24. *Armistead* disapproved *Poschman* on other grounds. (*Armistead, supra*, 22 Cal.3d at 204, n. 2, 149 Cal.Rptr. 1, 583 P.2d 744.)
25. (1990) 219 Cal.App 3d 422 436, 268 Cal Rptr. 244, 252-253.
26. The eighteen bulletins found to contain regulations are: Bulletin No. S-160 (2/11/71); Bulletin No. F-98 (3/19/71); Bulletin No. 11 (3/73); Bulletin No.48 (12/74); Bulletin No. 49 (12/74); Bulletin No. 59 (8/75); Bulletin No. 74 (5/76); Bulletin No.88B (6/77); Bulletin No. 71 (7/84); Bulletin No. 75 (4/85); Bulletin No. 75 Update (8/85); Bulletin No. 87 (2/86); Notice to Medi-Cal Providers (4/4/86); Bulletin No. 89 (4/86); Bulletin No. 97 (9/86); Bulletin No. 99 (11/86); Letter to all Skilled Nursing Facilities (12/2/86); Letter to Casa Bonita Convalescent Hospital (1/27/87).
- The nine bulletins found not to be regulations are: Bulletin No. S-146 (12/24/70); Bulletin No. S-224 (6/16/72); Bulletin entitled Medi-Cal Intermediary Operations (8/75); Bulletin No.69 (2/76); Bulletin No. 14 (4/16/81); Bulletin No. 72 (3/85); Bulletin No. 98 (10/86); Letter to Care Medical Mart (12/2/86); Memo regarding laxative brand (8/5/87).