Operations Memorandum - Medical Assistance
OPS011208
(Revised 8/29/02
Attachment F Revised 6/25/07))

12/31/01

SUBJECT: Medicaid Eligibility for the Breast and Cervical Cancer Prevention and Treatment Program

TO: Executive Directors

FROM: Linda A. Hicks, Official in Charge, Office of Income Maintenance

Purpose

To announce the implementation of the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program in Pennsylvania, effective January 1, 2002.

To provide the County Assistance Offices (CAOs) with information on the eligibility requirements and process, including a new Medicaid category and program status code, **PH 20**, that will be used to identify these women in the Client Information System (CIS).

Background

The BCCPT Act of 2000 amended Title XIX of the Social Security Act by giving states the option of providing full Medicaid benefits to a new group of individuals. This amendment provides healthcare coverage for treatment of breast and cervical cancer, including pre-cancerous conditions of the breast and cervix, in addition to full Medicaid benefits. Specifically, uninsured and underinsured women under the age of 65, screened and diagnosed with either breast or cervical cancer, including pre-cancerous conditions of the breast or cervix, by a provider or facility funded in full or part by the Centers for Disease Control and Prevention (CDC) under its National Breast and Cervical Cancer Early Detection Program (NBCCEDP), will be eligible for Medicaid benefits. Pennsylvania has chosen the Department of Health (DOH) HealthyWoman Project (HWP) as the screening entity for this program.

Eligibility requirements for this program require that a woman must:

- Be screened and diagnosed through the DOH HWP.
- Be uninsured or have no creditable healthcare insurance.
- Be under age 65.
- Be a U.S. citizen or qualified alien.

- Be a resident of Pennsylvania.
- Provide or apply for a social security number.

There are no Medicaid income and resource limits.

The HWP will be sending an informational letter to women enrolled in the project prior to or shortly after January 1, 2002 to advise them of the implementation of this program. The letter advises women who have breast or cervical cancer or a pre- cancerous condition of the breast or cervix and who are still in treatment that they may be eligible for Medicaid coverage. In many cases, these women will have already been screened and diagnosed with cancer or a pre-cancerous condition of the breast or cervix and in need of healthcare coverage.

However, to be determined eligible, the woman will still need to complete and sign a Breast and Cervical Cancer Prevention and Treatment Program Application (PA 600B). In order to do this, they must contact the HWP. The HWP will then forward the completed application to the appropriate CAO.

Discussion

Medicaid eligibility is available under the BCCPT Program effective January 1, 2002. The category is "PH" and the program status code is "20". In addition, a new set of application and redetermination forms have been created exclusively for this program.

- **Application Form and Enrollment Process**

Form: The PA 600B is a two-part initial application used by both the HWP and the Department of Public Welfare (DPW). Part A of the PA 600B is completed at the HWP screening site and contains the HWP enrollment and consent for release of information and the Medicaid rights and responsibilities. Part B of the PA 600B is completed by the applicant, the medical provider and the CAO.

Eligibility Begin Date: The Medicaid eligibility begin date under the BCCPT Program is the date of diagnosis. The date is determined as follows, using information from the PA 600B:

1. NEW APPLICANT

- The eligibility begin date is the date in PART II, Date of First Biopsy/Confirmatory Diagnosis.

2. WOMAN PREVIOUSLY SCREENED AND DIAGNOSED BY A NON-HWP PROVIDER

- The eligibility begin date is the Date of First Biopsy in PART II or up to 90 days prior to the date the woman signs the HWP Enrollment Information form, whichever date is later.

3. WOMAN SCREENED AND DIAGNOSED BY THE HWP PRIOR TO JANUARY 1, 2002, AND STILL IN NEED OF TREATMENT

- The eligibility begin date is up to 90 days prior to the date the woman signs the HWP Enrollment Information form. (NOTE: never further back than January 1, 2002.)

4. WOMAN SCREENED AND DIAGNOSED BY THE HWP AFTER JANUARY 1, 2002, INDICATED THAT SHE DID NOT WISH TO APPLY FOR MEDICAID UNDER THE BCCPT PROGRAM AT THAT TIME, IS STILL IN NEED OF TREATMENT AND NOW WISHES TO APPLY FOR MEDICAID UNDER THE BCCPT PROGRAM

- The eligibility begin date is the Date of First Biopsy in PART II, or up to 90 days prior to the date the woman re-signs and re-dates the original HWP Enrollment Information form.

Process: The enrollment process is as follows:

- A woman presents at an HWP screening site and completes the BCCPT Program application Part A of the PA 600B. The HWP provider will screen for breast and/or cervical cancer, or a pre-cancerous condition of the breast or cervix. If the woman has a positive diagnosis, she will be referred for further testing to confirm the diagnosis. In this situation, the HWP screening site keeps Part A of the PA 600B and provides the woman with Part B of the PA 600B, that she takes with her.
- The provider of these services completes Part B of the PA 600B and returns it to the HWP contractor. (See Attachment A)
- The HWP contractor mails or faxes Part A and Part B of the PA 600B to the Medicaid Outreach Contact Person in each CAO (See Attachment B).
- The CAO authorizes Medicaid under the BCCPT Program for the woman without creditable coverage healthcare coverage.

The authorization must be completed within five work days of receiving the BCCPT Medicaid eligibility application. In those situations where the referral to the Health Insurance Premium Program (HIPP) is required to determine creditable coverage, the five work day requirement begins from the date a response is received from HIPP (see section titled, "Creditable Coverage Requirements").

NOTE: A negative diagnosis will not generate a BCCPT Medicaid eligibility application to the CAO.

Each application is reviewed for other categories of Medicaid based upon information provided on the initial application. If an application is pending in CIS and a BCCPT Medicaid eligibility application comes into the CAO, the worker must add PH 20 to the category registration screen (CAADSP) and authorize the PH 20 budget, if eligible. The remaining budgets are set to "pend" status until an eligibility decision is made. A "P" must be entered in the application type field on the application registration screen (CAAREG) in order for the provider to receive a notice. Yearly redeterminations are required. A partial redetermination will be required when the estimated length of treatment is less than twelve months.

NOTE: Do not delay the opening of Medicaid under BCCPT Program while reviewing for other categories of Medicaid.

- **Retroactive Medicaid eligibility under BCCPT**

- A woman's eligibility for retroactive Medicaid under the BCCPT Program can begin up to three months prior to authorization but, no earlier than January 1, 2002. All eligibility requirements under the BCCPT Program must be met during the retroactive period including screening at an HWP program site and diagnosis of breast and cervical cancer, or a pre-cancerous condition of the breast or cervix.
- Retroactive Medicaid eligibility under the BCCPT Program will pay for needed breast and cervical cancer treatment (services) as well as other medically necessary health services as long as the provider is enrolled in the Medicaid program. (Note: Screenings through the HWP are ineligible for payment.)

- **Redetermination Forms and Process**

General redetermination procedures:

- Approximately **45 days prior** to the partial or annual redetermination due date, the CAO mails the client a PA 600BP or PA 600BR along with the cover letter (See Attachment C and Attachment D).
- The client and her medical provider complete the appropriate information on the form and return the completed document to the Office of Medical Assistance Programs (OMAP) by the specified due date.
- OMAP will receive bi-weekly CIS reports, which contain case information, and the partial or annual redetermination due dates for all PH 20 budgets. OMAP will establish a control file for the receipt of the PA 600BP and PA 600BR.
- OMAP will review all medical documentation under the BCCPT Program for medical necessity using the established criteria developed by the Office of the Medical Director (OMD). This review will be completed within ten days of receiving the PA 600BP or PA 600BR.
- OMAP will complete Part III of the PA 600BP or PA 600BR and fax the form to the CAO. If OMAP does not receive a redetermination document for a PH 20 budget that is due, they will fax a separate document to the CAO stating that a PA

600BP or PA 600BR was not received. The CAO will take action to discontinue benefits under the BCCPT Program.

NOTE: The CAO cannot start the process of terminating benefits under the BCCPT Program prior to receiving notification from the OMAP.

NOTE: For administrative issues related to sending information between the Office of the Medical Director and the CAOs, please contact:

Grace Martinec
Office of Medical Assistance Programs
(717) 772-6181

Partial redetermination:

Form: The PA 600BP is completed by the client, the medical provider, OMAP and the CAO.

Process:

- A partial redetermination will be required for each woman enrolled under the BCCPT Program whose initial length of treatment is expected to last less than twelve months.
- The partial review date will be set based upon the three-digit ICD.9 Code from Part II of the PA 600B, PA 600BP and PA 600B that will be data-entered on the CADISB screen in CIS. An alert will be generated as a reminder to the CAO worker to complete a partial review.
- At the partial review, the PA 600BP is reviewed by OMAP prior to continuing Medicaid eligibility. If the new medical certification indicates treatment is still needed, the CADISB screen is updated based upon OMAP's recommendation. The new partial review date is based upon the expected length of treatment date (ICD.9 Code) but can never be greater than the twelve month redetermination date that will be set at the initial application or redetermination date even if the need for treatment is expected to be twelve months or greater.
- If OMAP states that the treatment is no longer required, the CAO must send the appropriate notice to the woman proposing to terminate Medicaid under the BCCPT Program and review for other categories of Medicaid.
- No signature by the woman is required as part of the partial redetermination process.

Annual Redetermination:

Form: The PA 600BR is completed by the client, the medical provider, OMAP and the CAO.

Process:

- A redetermination is required every twelve months for a woman enrolled in Medicaid under the BCCPT Program who continues to require treatment for breast and cervical cancer including a pre-cancerous condition of the breast or cervix.
- A redetermination alert will be generated. At the annual redetermination, the eligibility factors requiring verification are creditable coverage if indicated on the redetermination document and the need for continued treatment. The client must provide the healthcare coverage information as a condition of continued eligibility under the BCCPT Program.
- Staff from HIPP will determine creditable coverage within five days. The CAO completes the BCCPT Creditable Coverage Verification Form and faxes or e-mails it to the appropriate HIPP Regional Office (See Attachment E).
- The provider must complete the PA 600BR stating the need for continued treatment.
- The PA 600BR is reviewed by OMAP prior to the CAO continuing Medicaid eligibility. The CAO worker will either continue Medicaid eligibility or terminate eligibility under the BCCPT Program based upon OMAP's recommendation even if it differs from what the provider states on the document.
- The CAO worker must review the redetermination document for other categories of Medicaid. In addition, the woman must sign this form and acknowledge her rights and responsibilities.

- **Creditable Coverage Requirements**

- A requirement for a woman to receive Medicaid coverage under the BCCPT Program is that she has no insurance or that her insurance does not provide coverage for treatment of her cancerous or pre-cancerous condition of the breast or cervix. The term "creditable coverage" is defined under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of PHS Act (42 U.S.C. 300gg(c). Essentially, any existing healthcare coverage is reviewed to determine whether the insurance is sufficient to cover all the medical services for breast and cervical cancer, including pre-cancerous conditions of the breast or cervix. **If the woman's healthcare coverage covers all of the screening, diagnostic and required treatment, the woman is ineligible for Medicaid under the BCCPT Program. Lack of prescription coverage under a healthcare plan is not a factor in meeting the requirement of creditable coverage as defined by HIPAA. Therefore, a woman with healthcare coverage which meets HIPAA requirements but which excludes prescription coverage is ineligible for Medicaid under the BCCPT Program because she is considered to have "creditable coverage". If the existing healthcare coverage has been exhausted, the woman is considered not to have "creditable coverage" and is eligible for Medicaid under the BCCPT Program as long as the other eligibility requirements are met.** A determination of creditable coverage must

be made for all applications that indicate the applicant/recipient has other healthcare coverage prior to the CAO authorizing Medicaid under the BCCPT Program. A determination of creditable coverage must also be made if a woman reports obtaining coverage at redetermination or at any other time during her Medicaid eligibility.

- Staff members from the regional HIPP offices will be responsible for determining creditable coverage within five days of receiving the referral from the CAO.
- Attachment E outlines the CAO procedures for completing and e-mailing the BCCPT Creditable Coverage Verification Form to the regional HIPP offices. The HIPP representative will e-mail the completed document back to the CAO.
- The CAO worker must data enter TPL information for all cases with healthcare coverage.

- **Termination of Medicaid under BCCPT Program**

- Medicaid eligibility under the BCCPT Program ends when the woman no longer meets the specific requirements under this program: the woman has attained age 65, the woman has obtained creditable coverage or the woman is no longer in need of treatment for breast and cervical cancer including pre- cancerous conditions of the breast and cervix.
- Non-compliance is the failure of the client to complete a partial or complete redetermination. At the partial redetermination, this is when the client fails to provide the necessary medical documentation stating the need for continuing treatment. At the complete redetermination, this is when the client fails to submit a redetermination form and/or the necessary medical documentation stating the need for continuing treatment. The CAO will determine non- compliance and send the proper notice to the client to terminate Medicaid under the BCCPT Program.
- Medicaid must be continued in other categories if the CAO has sufficient information to make that eligibility determination. As long as an individual remains eligible for Medicaid under the BCCPT Program, eligibility under the BCCPT Program should not be terminated in order to authorize Medicaid in a category that provides lesser benefits, such as the Medically Needy Only category.

- **CAO responsibilities**

- MA Outreach Liaison – This individual will receive and monitor all the BCCPT applications sent to their CAO from the HWP. They are to ensure that BCCPT applications without healthcare coverage are processed within five work days of receipt. Applications with insurance where a determination of creditable coverage must be made will take longer to process because that information has to be reviewed by the HIPP staff, which can take up to five additional days.

- Review application for other categories of Medicaid – All applications received for the BCCPT program must be reviewed for other categories of Medicaid. The CAO will use information on the PA 600B - Part A, questions 1 through 4 to help determine whether other categories of Medicaid should be explored. If the woman or her household appears eligible for other categories of Medicaid based upon this information, the CAO must first authorize benefits under BCCPT if the woman is otherwise eligible, then follow up with the woman or her household to obtain the necessary information to make the eligibility determination for other categories of Medicaid. If the household is eligible for another Medicaid NMP category, authorize Medicaid in that category. If the household is eligible in the MNO category, open all members except the BCCPT woman in the MNO category, the BCCPT woman remains PH 20.

- **Notices/Reason Codes**

- Eligible – Reason code **337** is used to notify women of their eligibility under the BCCPT Program. Reason code **337** is the only reason code to be used for eligibility under the BCCPT Program.
- Ineligible – Reason code **338** is used to notify a woman of her ineligibility under the BCCPT Program. The two options under this reason code are:

  - Option 1 – Ineligibility due to a woman having creditable insurance coverage.
  - Option 2 – Ineligibility due to a woman being over the age of 65.

- Discontinue – Reason code 339 is used to notify a woman that her eligibility in the BCCPT Program has discontinued. The five options under this reason code are:

  - Option 1 – Benefits under the BCCPT Program are being discontinued because the woman is over age 65.
  - Option 2 – Benefits under the BCCPT Program are being discontinued because the individual is no longer in need of treatment for breast or cervical cancer including pre-cancerous conditions of the breast or cervix based upon information provided and reviewed by OMAP.
  - Option 3 – Benefits under the BCCPT Program are being discontinued because the woman has now obtained creditable coverage insurance that pays for the treatment of breast and cervical cancer including pre- cancerous conditions of the breast or cervix.
  - Option 4 – Benefits under the BCCPT Program are being discontinued because the woman failed to complete the annual redetermination under the BCCPT program.
  - Option 5 – Benefits under the BCCPT Program are being discontinued because the woman failed to complete the partial redetermination.

- Other applicable reason codes – The following reason codes are also to be used when determining ineligibility under the BCCPT Program;

  - reason code 052 not a resident of Pennsylvania and
  - reason code 046 for failure to provide or apply for a social security number

- **Appeals**

- Each recipient under the BCCPT Program has the right to ask for a hearing to appeal a decision to discontinue her eligibility under this program. See Supplemental Handbook Chapter 870.
- Staff from OMAP and the CAO will attend hearings when benefits are terminated due to the woman no longer needing treatment.
- Staff from HIPP and the CAO will attend hearings when benefits are terminated due to the woman having attained creditable insurance.

- **Healthcare Benefit and Delivery System**

- Healthcare Benefit Package (HCBP) – Women age 21 and older are enrolled in Medicaid under the BCCPT Program are in HCBP #2. Women under age 21 are enrolled in HCBP #1. They are entitled to full Medicaid benefits.
- Delivery System – Women enrolled in Medicaid under the BCCPT Program are covered under the Fee-For-Service delivery system.

Note: These women are not enrolled in HealthChoices, the managed care delivery system, or in voluntary managed care.

Next Steps

1. Review this Operations Memorandum with appropriate staff.
2. Effective January 1, 2002, authorize Medicaid eligibility for women found eligible for BCCPT under the HWP as PH20.
3. This memorandum remains in effect until the information is updated in the Medicaid Eligibility Handbook.
4. Contact your Area Manager if you have any questions regarding this policy.

Attachments

Attachment A - HealthyWoman Project Contractors Providing Services List
Attachment B - MA Outreach Contact Persons List
Attachment C - Cover Letter BCCPT Partial Redetermination
Attachment D - Cover Letter BCCPT Annual Redetermination

Attachment E - HIPP BCCPT Template

Attachment F - HIPP Regional Office Listings

Last modified:

Policy Clarification - Medical Assistance - BCCPT
PMC10112338

Submitted: January 31, 2002 Agency: Warren CAO

Citations:

Subject: PH Member's Income in MA Computation for Family

If a PH20 budget is opened and there are other household members applying for MEDICAID, would the PH eligible client's income and resources be excluded when deterring Medicaid for the other household members?

Response By: C. Braxton 4/3/02

The income and resources of the PH 20 member is treated as follows when determining Medicaid eligibility for other household members:

If the entire household including the PH 20 member is determined eligible for NMP, all household income is counted. The PH 20 member is converted to the NMP category, unless the NMP category is GA-related then the PH 20 member remains a PH 20 and all other members are NMP GA-related.

If the entire household including the PH 20 member is determined eligible for MNO, all household income is counted. The PH 20 member remains PH 20 and the other members are MNO.

If members of the household are eligible for the Healthy Beginnings program, the income of the PH 20 member is counted for that determination. The PH 20 member remains PH 20.

Resources are excluded for households with children under the age of 21 when determining Medicaid eligibility.

Last modified:

Policy Clarification - Medicaid - TANF
PMT10704360

Submitted: 2/10/03

Agency: Monroe CAO

Citations: OPS-01-12-08; MAEH 318.622, MAEH 360.213, MAEH 361.211

Subject: Eligibility for Incentive/Received BCCPT

We have a client who was eligible for MA in the BCCPT category. She no longer has that medical need, and is ineligible in that category. She has a child receiving MA in the Healthy Beginnings category. The client is now working.

To determine any continuing MA eligibility, is she, as a previous recipient of BCCPT, entitled to the incentive?

Response By: D. Hoffman 2/11/03

Yes, it is a valid medical category and policy should be applied accordingly.

The Breast and Cervical Prevention and Treatment Act of 2000 provides Medicaid coverage for certain women screened and found to have breast or cervical cancer under a federally funded screening program.

Although BCCPT is an optional Medicaid category, a woman found eligible under this program is entitled to full Medicaid, and therefore eligible to receive the incentive in another Medicaid category upon termination of Medicaid under BCCPT if she meets incentive eligibility requirements in the other category.

Last modified:

Policy Clarification - Medicaid - BCCPT
PMC11736317
(Revised 6/15/04)

Submitted: 4/04

Agency: Clarion CAO

Citations:

Subject: Medical Transportation for BCCPT Recipients

Do recipients of BCCPT qualify for special allowances for medical transportation, such as transportation, overnight lodging and meals? The system will not permit an allowance for a PH20 recipient.

Response By: K. Kistler 5/20/04

Yes, PH20 recipients are entitled to full Medicaid benefits, including transportation. They are eligible for services through the MATP or allowances through the CAO, whichever is applicable.

The initial program requirements for BCCPT prevented special allowances from being issued for this category. A data processing service request has been submitted to allow recipients in the BCCPT program to receive special allowances. You will notified via Daily Status when these software changes have been implemented.

Last modified:

Policy Clarifications - Medicaid - BCCPT
PMC12853317

Submitted: 2/2/06 **Agency: CAOs**

Citations:

Subject: Medicare Recipients and BCCPT

Is a Medicare recipient eligible to receive the Breast and Cervical Cancer Prevention and Treatment Program (BCCPT), PH/20?

Response By: Division of Health Services **Date: 2/9/06**

NO, a Medicare recipient is not eligible to receive PH/20.

Specific guidance regarding eligibility for the Breast and Cervical Cancer Prevention and Treatment Program (BCCPT) is provided in Chapter 317 of the Medicaid Eligibility Handbook.

As stated in Section 317.1, General Policy, the CAO is responsible for authorizing all applications for BCCPT received from the Healthy Woman Program contractor. The only eligibility factor needing immediate verification by the CAO is that of creditable coverage when the client indicates health insurance on the applications. Creditable coverage is determined by the staff at each regional Health Insurance Premium Program (HIPP) office.

Section 317.13, Verification, specifies that the following eligibility requirements must be verified:

Creditable coverage. The term "creditable coverage" is defined under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of Public Health Services Act (42 U.S.C. 300gg(c). All healthcare coverage will be reviewed to determine whether the insurance is sufficient to cover all the medical services for breast and cervical cancer, including pre-cancerous conditions of the breast or cervix. Staff members from the regional HIPP offices will be responsible for determining creditable coverage within five days of receiving a referral from the CAO. See 317, Appendix E for the HIPP BCCPT Template and Appendix F for instructions on HIPP referrals and HIPP Regional Office listings.

Note: A determination of creditable coverage must also be made if a woman reports obtaining coverage at redetermination or at any other time during her Medicaid eligibility.

Operations Memorandum - Medicaid
OPS070304

SUBJECT: **Breast and Cervical Cancer Prevention and Treatment (BCCPT) Co-Payment Reimbursement**

TO: **Executive Directors**

FROM: **Joanne Glover, Director, Bureau of Operations**

Purpose

To notify County Assistance Offices of Federal Medicaid (MA) changes which exclude services provided to BCCPT recipients from co-payment requirements, and to provide information regarding recipient refunds.

Background

As described in Medical Assistance Bulletin 99-06-12, dated December 10, 2006, under current MA regulations (55 Pa, Code 1101.63(b)), services provided to individuals receiving benefits under BCCPT are excluded from co-payment requirements. These changes were mandated by Federal law and became effective March 31, 2006 .

Discussion

Effective March 31, 2006 , all services provided to MA recipients who are eligible under the BCCPT coverage group were excluded from MA program co-payment requirements. On December 10, 2006 , MA participating providers discontinued collecting co-payments for services provided to BCCPT recipients identified by category/program status code PH/20.

The Office of Income Maintenance (OIM) has identified more than 1,700 recipients who may have made co-payments for services provided between March 31, 2006 and December 10, 2006 . OIM mailed a notice (copy attached) on March 8, 2007 to each individual who may be eligible for a refund of co-payments made during this period.

The Office of Medical Assistance Programs (OMAP) will issue reimbursements to those BCCPT recipients for co-payment amounts that, according to the Department of Public Welfare's claims history records, were paid for services on or after March 31, 2006. OMAP will begin to mail these reimbursement checks around the middle of April 2007.

If individuals receiving benefits under BCCPT call the CAO with questions about the refund, refer them to OMAP at 1-800-509-0987 or 1-866-542-3015 (TDD/TTY 1-877-202-3021) Monday through Friday from 8:00 a.m. to 5:00 p.m.

Next Steps

1. Review this Information Memorandum with appropriate staff.
2. Contact your Area Manager if you have any questions.

Attachment: BCCPT Refund Notice

Policy Clarifications - Citizenship & Identity Verification (Medicaid) BCCPT
PVM13767322
PMC13767317

Submitted: 06/07 **Agency: CAOs**

Citations:

Subject: BCCPT Applications without Verification of Citizenship or ID

Per MEH 317.7 and OPS-01-12-08 BCCPT applications must be authorized within five work days from the HIPP response if determined not to have creditable coverage.

Policy Clarification PVM-13235-322/PMA-13235-322 clarifies that citizenship and identity verification requirements, addressed in OPS 06-07-05, apply to BCCPT.

Since BCCPT applications are not received at the CAO with the required citizenship and identification or even a PA1809, which policy takes precedence? Are we to authorize within five days without meeting the citizenship and identification requirements prior to authorization, or are we to delay opening until we have all required documents and disregard the five day processing limit?

Response By: John Sabol **Date: 6/28/07**

You should not delay opening a BCCPT budget or any other Medicaid group while awaiting proof of citizenship and identity.

You can authorize benefits for BCCPT without first obtaining citizenship and identity documentation. OPS-06-07-05 clearly states that an applicant who does not have proof of citizenship and/or identity cannot be denied Medicaid, if otherwise eligible.

OPS-01-12-08 also states that the opening of Medicaid under the BCCPT program should not be delayed.

Note: The individual must cooperate fully with the CAO in obtaining the necessary documentation.