DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 09-02
2. STATE: Virgin Islands
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS NEW PLAN | X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
1902(a)(69) of the Act

7. FEDERAL BUDGET IMPACT
a. FFY 2009 $ 0
b. FFY 2010 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A page 1A
Attachment 3.1-A page 2
Attachment 3.1-A page 12A
Attachment 3.1-B page 2
Attachment 3.1-B page 15-16
Attachment 3.1-B page 14-14A

***** SEE REMARKS**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 3.1-A page 1A
Attachment 3.1-A page 2
Attachment 3.1-B page 2
Attachment 3.1-B page 15-16
Attachment 3.1-B page 14-14A

10. SUBJECT OF AMENDMENT

Clarifies coverage provisions, including but not limited to prior authorization requirements, in the areas of EPSDT services, FQHC services, laboratory and X-ray services, family planning services, dentures, and prosthetic devices

11. GOVERNOR'S REVIEW *(Check One)*

GOVERNORS OFFICE REPORTED NO COMMENT

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

Julia 6/29/09

13. TYPED NAME Julia Sheen

14. TITLE Acting Commissioner, Department of Health

15. DATE SUBMITTED 06/29/2009

16. RETURN TO:

Julia Sheen

DOH, BHIMA

3500 Richmond

Charles Harwood Complex

Christiansted, USVI 00820

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED DEC 0 1 2009

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL APR 0 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME **Sue Kelly**

22. TITLE **Associate Regional Administrator**
Division of Medicaid and State Operations

22. REMARKS

Originally submitted SPA was divided into 5 SPAs.
Originally submitted pages were replaced with new pages via State's e-mail on 11/16/09.
Attachment 3.1-A, Page 1, Page 7, Page 10, Page 10A, Page 11, Page 11A, and Page 13.
Attachment 3.1-B, Page 2, Page 6, Page 13, Page 14, Page 14A, and Page 15.
Attachment 4.19-B, Page 4.