COMMONWEALTH of VIRGINIA

MIRA SIGNER
ACTING COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 12, 2019

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment, Senator Hanger, and Delegate Jones:

Item 312.H.2. of the 2019 Appropriation Act, requires the Department of Behavioral Health and Developmental Services (DBHDS) to report on the Part C Early Intervention System in Virginia.

Please find enclosed the report in accordance with Item 312.H.2. Staff at the department are available should you wish to discuss this request.

Sincerely,

Mira Signer
Acting Commissioner

Enc.
Cc: Hon. Daniel Carey., M.D.
Marvin Figueroa
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Report on Virginia's Part C Early Intervention System

July 1, 2018 – June 30, 2019

Item 312 H.2.

November 15, 2019

DBHDS Vision: A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 •
FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Virginia's Part C Early Intervention System

Preface

Item 312.H2 of the 2019 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to submit an annual report to the Governor and the General Assembly.

> *H2. By November 15 of each year, the department shall report to the Chairmen of the House Appropriations and Senate Finance Committees on the (a) total revenues used to support Part C services, (b) total expenses for all Part C services, (c) total number of infants, toddlers and families served using all Part C revenues, and (d) services provided to those infants, toddlers, and families.*

Virginia's Part C Early Intervention System

Table of Contents

Introduction

Congress enacted early intervention legislation in 1986 as an amendment to the Education of Handicapped Children's Act (1975) to ensure that all children with disabilities from birth to the age of three would receive appropriate early intervention services. This amendment formed Part H of the Act, which was re-authorized in 1991 and renamed the Individuals with Disabilities Education Act (IDEA).When the IDEA was re-authorized in 1998, Part H became Part C of the Act.IDEA was reauthorized most recently in December 2004. Virginia has participated in the federal early intervention program, under IDEA, since its inception.

In 1992, the Virginia General Assembly passed legislation that codified an infrastructure for the early intervention system that supports shared responsibility for the development and implementation of the system among various agencies at the state and local levels. The Department of Behavioral Health and Developmental Services (DBHDS) was designated and continues to serve as the lead state agency for implementing this act. The broad parameters for the Part C system are established at the state level to ensure implementation of federal Part C regulations. Within the context of these broad parameters, 40 local lead agencies manage services across Virginia.

In 2012, the General Assembly appropriated the state funds necessary to increase the Medicaid reimbursement rate for early intervention targeted case management from $120 per month to $132 per month for FY 2013, beginning July 1, 2012. In order to address a looming $8.5 million deficit in funding for early intervention due to significant increases in the number of children served and static federal funding, the General Assembly provided critical support for Virginia's early intervention system in 2013 by allocating an additional $2.3 million in state general fund dollars for early intervention in FY 2013 and another $6 million for FY 2014. In recognition of continued growth, annual increases were allocated in FY 2015 – FY 2018 and the General Assembly allocated a total of almost $18.6 million and just over $19.7 million for FY 2019 and FY 2020, respectively.

In FY2019, there were a growing number of indicators of significant stress on the early intervention system, including increasing reports of fiscal and provider shortages with resulting impacts on the timeliness and quality of critical early intervention services received by infants, toddlers and their families.

- The number of children served in the Part C early intervention system increased by 4% from FY 2018 to FY 2019. From FY 2012 to FY 2019, the number of children served in early intervention increased by 34%. While the General Assembly has increased state Part C funding to help support this growth, the total revenue available to support the system has increased by only 19%.

- Increasing costs over time have resulted in widespread reports from service providers that the early intervention rates set in 2009 no longer cover the cost of providing early intervention services. In addition to impacting the need for additional funds, this discrepancy in cost versus reimbursement is contributing to increasing provider shortages and, therefore, high caseloads and multiple instances of noncompliance with federal

requirements.

- Fourteen local systems requested additional funds to pay for needed early intervention services in FY 2019. S tate Part C funds allocated by the General Assembly through a caboose bill were the only additional funds available and addressed about 40% of the requests for additional funding. As a result, one local system notified the DBHDS that they were holding high-level discussions about relinquishing their responsibility as the local lead agency. Ultimately, that local system decided to remain as the local lead agency for that area.

To the maximum extent possible, the following narrative, charts and other graphics respond to the legislative requirements as delineated in Item 312.H2. The following data is based on revenue and expenditure reports received from the forty local lead agencies and includes data from the private providers with whom the local lead agencies contract.

Total Revenue Used to Support Part C Services

The table below describes the total revenue to support Part C Early Intervention Services in FY 2019.

Revenue Source	FY19 Revenue
Medicaid, Including Targeted Case Management	**$23,306,229**
State Part C Funds	**$19,098,605***
Local Funds	**$8,503,685**
Federal Part C Funds	**$8,359,376***
Private Insurance and TRICARE	**$5,170,401**
Family Fees	**$927,199**
In-Kind	**$841,345**
Other State General Funds	**$464,944**
Grants/Gifts/Donations	**$17,722**
Other	**$1,668,446**
Total	**$68,357,952**

*These figures are the amount of Part C funding actually received by local systems. In some cases, local systems had more funds than indicated in the allocation table below because they had retained earnings from the previous fiscal year.

The following table represents the federal and state revenue allocated by DBHDS to the forty local lead agencies:

Funds Allocated by Local Lead Agency*

Infant & Toddler Connection of:	State	Federal
Alexandria	$ 430,859	$ 201,247
Alleghany-Highlands	$ 87,203	$ 50,788
Arlington	$ 806,972	$ 368,158
Augusta-Highland	$ 128,849	$ 68,022
Blue Ridge	$ 580,114	$ 250,713
Central Virginia	$ 414,118	$ 185,720
Chesapeake	$ 674,797	$ 308,246
Chesterfield	$ 814,434	$ 367,088
Crater District	$ 204,754	$ 92,691
Cumberland Mountain	$ 83,152	$ 46,221
Danville-Pittsylvania	$ 158,054	$ 64,189
DILENOWISCO	$ 109,962	$ 57,719
Eastern Shore	$ 60,595	$ 38,620
Fairfax-Falls Church	$ 3,654,787	$1,622,908
Goochland-Powhatan	$ 123,121	$ 68,075
Hampton-Newport News	$ 562,582	$ 256,025
Hanover	$ 217,590	$ 99,625
Harrisonburg-Rockingham	$ 247,397	$ 118,183
Heartland	$ 158,841	$ 75,301
Henrico-Charles City-New Kent	$ 673,417	$ 301,452
Highlands	$ 87,275	$ 48,652
Loudoun	$ 1,045,854	$ 468,842
Middle Peninsula-Northern Neck	$ 425,848	$ 131,675
Mount Rogers	$ 118,610	$ 61,243
New River Valley	$ 285,404	$ 143,676
Norfolk	$ 564,981	$ 248,115
Piedmont	$ 120,071	$ 63,031
Portsmouth	$ 221,615	$ 80,190
Prince William, Manassas and Manassas Park	$ 881,566	$ 392,631
Rappahannock Area	$ 769,005	$ 345,351
Rappahannock-Rapidan	$ 179,006	$ 90,184
Richmond	$ 382,581	$ 173,797
Roanoke Valley	$ 332,286	$ 153,038
Rockbridge Area	$ 120,164	$ 58,286
Shenandoah Valley	$ 397,640	$ 168,125
Southside	$ 93,326	$ 52,266
Staunton-Waynesboro	$ 135,355	$ 62,801
Virginia Beach	$ 1,242,900	$ 557,408
Western Tidewater	$ 413,079	$ 179,098
Williamsburg-James City-York-Poquoson	$ 578,979	$ 250,329
Total	$18,587,143	$8,369,729

*See Appendix A for a listing of the localities included in each system.

Total Expenses for All Part C Services

The table below describes the total expenditures for Part C Early Intervention (EI) Services in FY 2019.

Service	FY 19
Assessment for Service Planning	**$3,815,872**
Assistive Technology Devices	**$30,057**
Audiology	**$26,197**
Counseling	**$8,560**
Developmental Services	**$4,401,493**
Evaluation for Eligibility Determination	**$1,231,630**
Health	**$117,048**
Nursing	**$10,183**
Nutrition	**$13,596**
Occupational Therapy	**$3,167,647**
Physical Therapy	**$3,883,644**
Psychology	**$0**
Service Coordination	**$16,258,601**
Social Work	**$137,315**
Speech Language Pathology	**$8,232,646**
Transportation	**$83,235**
Vision	**$55,746**
Other Entitled Part C Services	**$647,767**
EI Services by Private Providers**	**$15,345,770**
Total-Direct Services	**$57,467,007***

*The local lead agencies reported an additional $9,295,125 of expenses related to the system components (administration, system management, data collection and training) that are critical to implementation of direct services. **Therefore, total expenses are $66,762,132**.

**The local expenditure reporting forms were revised in FY 2013 to eliminate duplicate reporting of expenses paid with Part C funds. It was not possible to eliminate the duplication by service category, so private provider expenses for all early intervention services are reported as a lump sum.

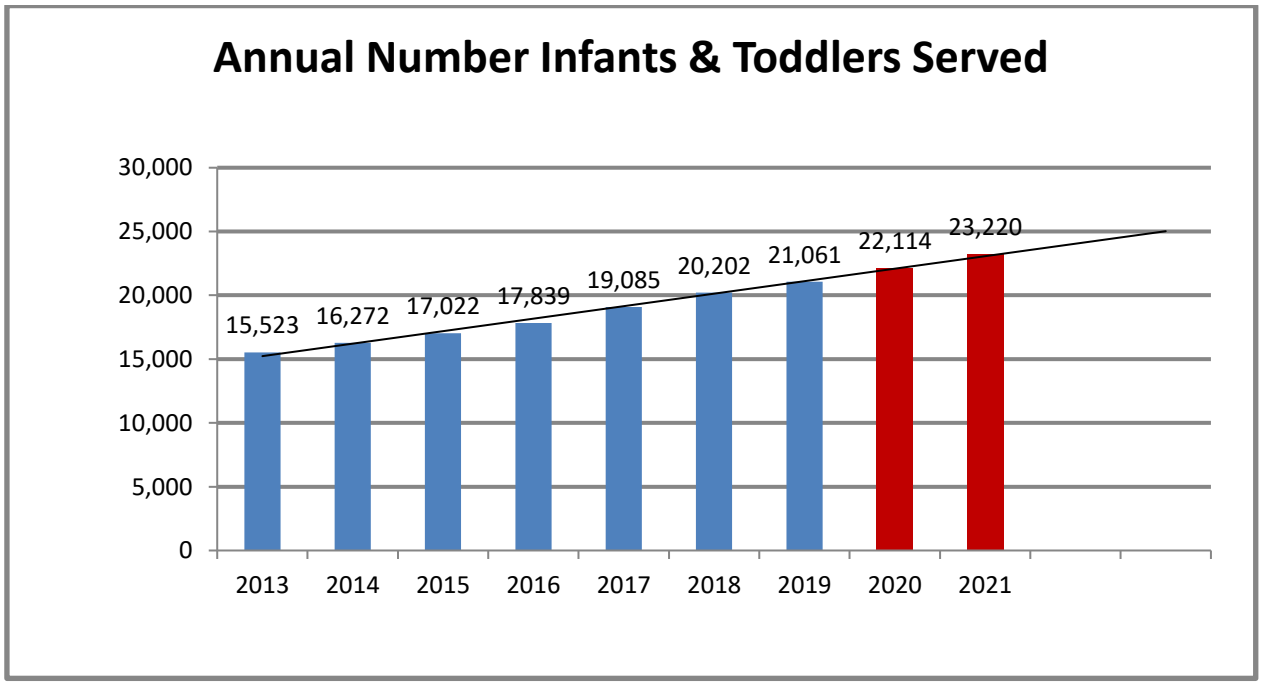
Total Number of Infants and Toddlers Served

The table below shows the total number of infants and toddlers evaluated by those who were eligible and entered services and by those who did not enter services since 2004.

Year	Total Number Served – Eligible and Entered Services	Total Number Evaluated Who Did Not Enter Services*
Dec. 2, 2003 – Dec.1, 2004	8,540	0
Dec. 2, 2004 – Dec. 1, 2005	9,209	0
July 1, 2006 – June 30, 2007	10,330	0
July 1, 2007 – June 30, 2008	11,351	1,760
July 1, 2008 –June 30, 2009	11,766	1,671
July 1, 2009 – June 30, 2010	12,234	1,494
July 1, 2010 – June 30, 2011	14,069	1,829
July 1, 2011 – June 30, 2012	15,676	1,797
July 1, 2012 – June 30, 2013	15,523	1,745
July 1, 2013 – June 30, 2014	16,272	1,720
July 1, 2014 – June 30, 2015	17,022	1,815
July 1, 2015 – June 30, 2016	17,839	1,976
July 1, 2016 – June 30, 2017	19,085	2,078
July 1, 2017 – June 30, 2018	20,202	2,150
July 1, 2018 – June 30, 2019	21,061	2,186

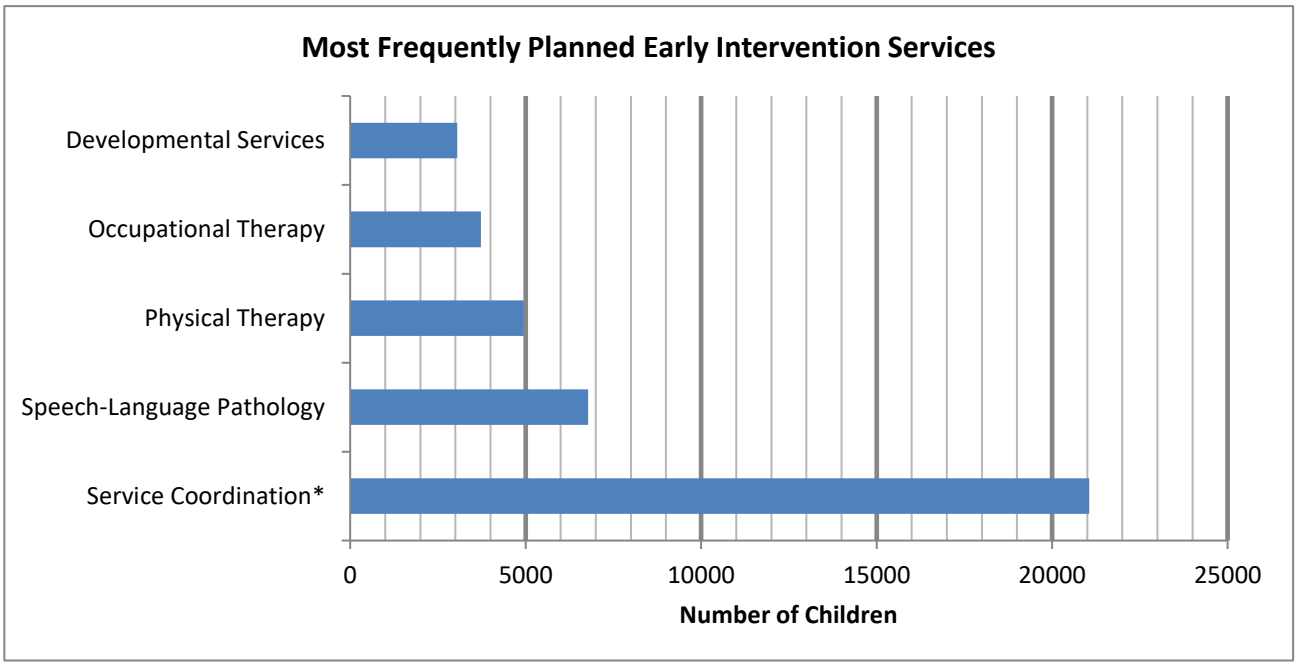
*These children received a multidisciplinary team evaluation to determine eligibility and, in some cases, an assessment for service planning, but did not enter services because they were either found ineligible for Part C, declined Part C early intervention services, or were lost to contact. Since evaluation and assessment, by federal law, must be provided at no cost to families, neither private insurance nor families can be billed for these services. Unless the child has Medicaid or TRICARE, federal and state Part C funds are generally used to pay for evaluation and assessment.

Using the total number of children served each year (annual child count), the chart below trends the projected number of eligible children served through 2021.



Services Provided to Eligible Infants and Toddlers

The chart and table below describe the types of services provided to eligible infants and toddlers and the total number of children receiving each service in FY 2019.



*All eligible children receive service coordination.

FY 2019 Estimates of Total Number of Children Receiving Each Service

Type of Early Intervention Service	% of Children with an Initial IFSP* Listing that Service on 12/1/18	Estimated # of Children with an Initial IFSP Listing that Service in FY 2019 (% Multiplied by Total Served)
Service Coordination	100%*	21,061
Speech-Language Pathology	32.2%	6,782
Physical Therapy	23.5%	4,949
Occupational Therapy	17.7%	3,728
Developmental Services	14.5%	3,054
Vision Services	0.7%	147
Audiology	0.7%	147
Other Entitled EI Services	0.3%	63
Social Work Services	0.2%	42
Assistive Technology	0.09%	19
Nutrition Services	0.05%	11
Sign Language & Cued Language	0.04%	8
Medical Services	0.01%	2

Nursing	0.01%	2
Counseling	0.01%	2
Health Services	0%	0
Psychological Services	0%	0
Transportation	0%	0

*All eligible children receive service coordination.
** IFSP = Individualized Family Service Plan**.**

In addition to the services listed on IFSPs, a total of 13,616 children received an evaluation to determine eligibility and/or an initial assessment for service planning in FY 2019.

Data Limitations

The existing early intervention data system, the Infant and Toddler Online Tracking System (ITOTS), was developed and implemented in 2001 primarily to meet annual federal reporting requirements related to child data. The system provides data on who is receiving services, including the number of children by local system, race/ethnicity, gender, age, and reason for eligibility. ITOTS allows for the collection of data on the services planned on each child's initial IFSP but does not provide for the collection of data on how those services change over time, on delivered services, or on payment for services. As a result, there is no mechanism available for local systems or for DBHDS to get the kind of real-time, ongoing data necessary to effectively and efficiently monitor service delivery for individual children, to study trends and patterns, or to monitor funding sources and service costs by child or by local system.

Since no financial data for Part C services is collected through ITOTS, DBHDS must rely on a burdensome paper process for collecting and reporting data on the expenses associated with providing services and the revenue sources that are accessed in providing services. Local lead agencies and private providers each maintain separate billing and accounting systems, so there is no method to reliably ensure non-duplication of reporting of expenses and revenues, with the exception of Medicaid, including Medicaid Targeted Case Management, revenue. Through a data exchange agreement between DBHDS and the Department of Medical Assistance Services (DMAS) for implementation of the Medicaid Early Intervention Services Program, DBHDS is able to report the amount of Medicaid funds used to support Part C early intervention services.

Non-duplication of revenue and expense reporting can only be fully ensured once a reliable statewide mechanism is implemented to collect or import data from local systems on expenditures and on the source and amount of revenue for every service delivered. DBHDS initially began developing an in-house data system solution to accomplish this task. After analyzing the lack of progress on this approach and exploring other options to address the current data system limitations, DBHDS determined that purchase of a vendor solution may be more cost and time-effective than continuing with in-house development. DBHDS is in the early stages of the procurement process.

Overall Fiscal Climate for Part C for FY 2019 and Beyond

While reported revenue kept pace with reported expenses for FY 2019, that data provides an incomplete and misleading picture of the actual financial situation for the early intervention system for several reasons:

- The completeness and accuracy of reported expense and revenue data is suspect since local lead agencies and private providers collect their data separately and there is no central mechanism to ensure reporting by all private providers or to ensure non-duplication.

- DBHDS was unable to fully meet local system needs for additional funds in FY 2019.

- Reported expenditures reflect the early intervention rate paid for each service, which may be lower than the full cost of providing that service.

- In some local systems, revenue exceeded expenditures due to provider shortages. Money was available, but no provider could be found to hire or contract with.

- Local systems with anticipated budget shortfalls used a variety of strategies, including reducing funding for system operations, like training; requiring the local system manager to also provide direct services to children and families; or increased caseloads, especially for service coordination, in order to ensure services for all eligible children and families. While these strategies assist local systems to operate within available funding and maintain compliance with federal and state requirements, long-term use of these strategies may negatively impact the quality of services delivered and eventually the outcomes for eligible children and families.

There are a growing number of indicators of significant stress on the early intervention system, including increasing reports of fiscal and provider shortages with resulting impacts on the timeliness and quality of services received by infants, toddlers and their families:

- The Medicaid Early Intervention Targeted Case Management program that began in October 2011ensures eligible children and families receive service coordination that is appropriate to the needs of infants, toddlers and their families. However, the Early Intervention Targeted Case Management reimbursement rate of $132 per month does not cover the expenses of providing this service. Those expenses were estimated at $175 per month when a cost study was conducted by DMAS in 2008 and updated in 2009. Given the level of case management provided in early intervention, the DMAS Provider Reimbursement Division has been supportive of increasing the EI case management rate to the same level as the developmental disability case management rate of $242.73 per month if funding were made available.

- The Medicaid Early Intervention Services Program continues to reimburse providers the full early intervention rate for services (other than service coordination) for children with Medicaid. However, the early intervention rates were set in 2009 and no longer

cover the cost for providing these services. Insufficient reimbursement rates make it impossible for early intervention programs to offer competitive salaries and contribute to workforce shortages.

- The transition of the Medicaid Early Intervention Program from fee-for-service to managed care starting in FY 2018 resulted in significant financial hardships for many early intervention providers. These challenges persisted through FY 2019. With the roll-out of the Commonwealth Coordinated Care Plus (CCC-Plus) and Medallion 4.0 programs, the Managed Care Organizations (MCOs) and early intervention providers have each had a steep learning curve in ensuring proper billing and reimbursement for early intervention services. During this learning process, early intervention providers have received frequent claim denials requiring significant time to address as well as delays in reimbursement. Although the Department of Medical Assistance Services protected the fee-for-service reimbursement amounts for early intervention in their contracts with the MCOs, there were widespread instances in FY 2019 of actual reimbursements (when finally received) being lower than these agreed upon amounts. Since many of the provider agencies that work in early intervention are small businesses, delayed and incorrect reimbursements pose a substantial risk to their financial viability and impact their willingness to continue to serve children and families through the early intervention system. Results of a survey conducted in March 2019 indicated five of the twenty-eight responding local systems had lost a provider/provider agency in FY 2019 as a result of MCO challenges.

- The number of children served in the Part C early intervention system increased by four percent from FY 2018 to FY 2019. From FY 2012 to FY 2019, the number of children served in early intervention increased by 34 percent. While the General Assembly has increased state Part C funding to help support this growth, the total revenue available to support the system has increased by only 19 percent.

- Fourteen local systems requested additional funds totaling $1,131,497 in FY 2019. These requests reflect only those additional funds needed to support the purchase of early intervention services (i.e., no salaried positions or system operation costs were considered). An additional $459,258 in FY 2019 state Part C funds allocated by the General Assembly through a caboose bill were the only additional funds available and addressed about 40% of the identified need. As a result, one local system notified the DBHDS that they were holding high-level discussions about relinquishing their responsibility as the local lead agency.

- A growing number of local systems reported provider shortages during FY 2019. While shortages are common nationally within some professional disciplines, inadequate early intervention reimbursement rates and challenges associated with the transition to Medicaid managed care are compounding the difficulty in attracting providers to and retaining providers in Virginia's Part C early intervention system. In general, many providers are more interested in providing outpatient, center-based services (rather than home and community-based services) because it pays more, there is no travel and productivity is higher. Provider shortages are leading to high caseloads, which, in turn,

contribute to the workforce challenges and potentially impact the quality of services provided.

- In FY 2019, as a result of budget shortfalls, personnel shortages or a combination of the two, at least five local systems slipped into non-compliance or were unable to timely correct non-compliance with federal timeline requirements. Infants, toddlers and their families experienced delays in timely evaluation, assessment and development of an Individualized Family Service Plan (IFSP) and/or the timely start of early intervention services once the IFSP was developed.

Looking ahead, the system is still growing each year and the following data further underscores the importance of continued revenue growth in order to support the system:

- When submitting their FY 2020 initial budgets, fourteen local systems reported a projected deficit for this year. The total projected shortfall is almost $1.6 million.

- Although diminishing overall, some MCO challenges are continuing in FY 2020. Even when the MCO reimbursement process works smoothly, it requires significantly more administrative time on the part of local lead agencies and provider agencies than Medicaid billing required under the fee-for-service arrangement. Under managed care, agencies now must work with six or seven MCOs (each with different procedures) rather than billing one entity, DMAS. The extra time and money required for Medicaid MCO billing decrease the personnel time and funding available for other early intervention functions, including service provision.

- Federal early intervention requirements necessitate aggressive outreach for public awareness and other efforts to identify all eligible children, meeting rigorous standards for timely and effective services, and ensuring there are no waiting lists. All states are also required by the U.S. Department of Education to implement strategies to improve outcomes for infants and toddlers. This worthwhile effort requires both human and fiscal resources. Unless funding stays apace with growth and the service needs of infants and toddlers in Early Intervention, Virginia runs the risk of additional noncompliance with federal requirements for the program.

Achieving a stable and sustainable fiscal structure for Virginia's early intervention system remains a top priority, as this is essential to ensuring an effective service system that leads to positive outcomes for infants and toddlers with disabilities and their families and maintains the highest determination provided by the United States Department of Education (Meets Requirements). To this end, DBHDS is:

- Closely monitoring the fiscal situation across local systems;

- Providing additional support to local system managers and local fiscal staff to ensure effective oversight of local budgets and spending as well as accurate reporting of revenues and expenditures;

- Working collaboratively with the Department of Medical Assistance Services (DMAS) and local systems to resolve reimbursement challenges under managed care;

- Requesting that DMAS expand Medicaid coverage of services delivered via telehealth to include early intervention services, thereby maximizing the availability of providers and expanding access to services;

- Engaging in discussion with DMAS and stakeholders to request that DMAS conduct a rate study to determine the amount of a rate increase needed to adequately cover the cost of providing early intervention services other than service coordination;

- Working to fund and develop a comprehensive early intervention data system that will collect the delivered service and non-duplicated revenue and expenditure data that is essential to effective fiscal oversight and planning at the state and local levels; and

- Exploring, with stakeholders, opportunities to expand the early intervention workforce and strategies to recruit and retain qualified providers.

The challenges and strategies identified above are consistent with those identified in the 2019 *Assessment of Virginia's Disability Services System: Early Intervention* report by the Virginia Board for People with Disabilities and the October1, 2019 letter to the Governor from the Virginia Interagency Coordinating Council.

Conclusion

Virginia and national data indicate that early intervention is leading to a number of positive outcomes for children and families. Research finds that early intervention reduces the need for special education and grade retention and reduces future costs in welfare and criminal justice programs. Estimates on the cost savings vary, but the long-term study associated with the Perry Preschool Project indicates that every dollar invested in early education will lead to at least a seven dollar return. As demonstrated by the data reported above, the funding provided by the General Assembly permitted local Part C early intervention systems to provide a wide variety of needed supports and services to more than 21,000 eligible infants, toddlers and their families during FY 2019. These funds also touched the lives of 2,186 additional infants, toddlers and families who received evaluations for eligibility determination and assessments upon referral to the Part C early intervention system even though they did not proceed on to receiving other early intervention supports and services. As the number of eligible infants and toddlers identified continues to increase and federal Part C funding levels remain static or fall, state Part C funding is critical to ensure all eligible children and families receive timely and appropriate early intervention supports and services.

Appendices

Appendix A Local System Names and Included Localities

Local System	Localities Included
Alexandria	City of Alexandria
Alleghany-Highland	Alleghany County; Town of Clifton Forge and City of Covington
Arlington County	Arlington County
Central Virginia	Counties of Amherst, Appomattox, Bedford and Campbell; Cities of Bedford and Lynchburg
Chesapeake	City of Chesapeake
Chesterfield	Chesterfield County
Williamsburg, James City, York	Counties of James City and York; Cities of Poquoson and Williamsburg
Heartland	Counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward
Cumberland Mountain	Counties of Buchanan, Russell, and Tazewell
Danville-Pittsylvania	Pittsylvania County; City of Danville
Eastern Shore	Counties of Accomack and Northampton
Fairfax-Falls Church	Fairfax County; Cities of Fairfax & Falls Church
Goochland-Powhatan	Counties of Goochland and Powhatan
Hampton-Newport News	Cities of Hampton and Newport News
Hanover County	Hanover County
Harrisonburg-Rockingham	Rockingham County; City of Harrisonburg
Henrico, Charles City, New Kent	Counties of Henrico, Charles City, and New Kent
Highlands	Washington County; City of Bristol, town of Abingdon
Loudoun County	Loudoun County
MiddlePeninsula-NorthernNeck	Counties of Essex, Gloucester, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, and Westmoreland; Towns of Colonial Beach and West Point
MountRogers	Counties of Bland, Carroll, Grayson, Smyth, and Wythe; City of Galax and Town of Marion
New River Valley	Counties of Floyd, Giles, Montgomery and Pulaski; City of Radford
Norfolk	City of Norfolk
Shenandoah Valley	Counties of Clark, Frederick, Page, Shenandoah, and Warren; City of Winchester
Piedmont	Counties of Henry, Franklin, and Patrick; City of Martinsville
DILENOWISCO	Counties of Dickenson, Lee, Scott and Wise; City of Norton
CraterDistrict	Counties of Dinwiddie, Greensville, Prince George, Surry, and Sussex; Cities of Colonial Heights, Emporia, Hopewell, and Petersburg
Portsmouth	City of Portsmouth
PrinceWilliam, Manassas, Manassas Park	Prince William County; Cities of Manassas, Manassas Park and Towns of Quantico
Rappahannock Area	Counties of Caroline, King George, Spotsylvania, and Stafford; City of Fredericksburg
Rappahannock-Rapidan	Counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock
RoanokeValley	Counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson; City of Charlottesville
Richmond	City of Richmond
BlueRidge	Counties of Botetourt, Roanoke and Craig; Cities of Roanoke and Salem
Rockbridge Area	Counties of Bath and Rockbridge; Cities of Buena Vista and Lexington
Southside	Counties of Brunswick, Mecklenburg, and Halifax; Towns of South Boston and South Hill
Augusta-Highland	Counties of Augusta and Highland
VirginiaBeach	City of Virginia Beach
Western Tidewater	Counties of Isle of Wight and Southampton; Cities of Franklin and Suffolk
Staunton-Waynesboro	Cities of Staunton and Waynesboro