COMMONWEALTH of VIRGINIA

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

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COMMISSIONER

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Monday, October 19, 2020

The Honorable Janet D. Howell, Chair
Senate Finance Committee
14th Floor, Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Howell:

Item 322.H2 of the 2020 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.*

Please find enclosed the report in accordance with Item 322.H2. Staff at the department are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE

cc: Vanessa Walker Harris, M.D.
Susan Massart
Mike Tweedy

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The Honorable Luke E. Torian, Chair
House Appropriations Committee
13th Floor, Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Delegate Torian:

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Virginia Department of Behavioral Health & Developmental Services

Report on Virginia's Part C Early Intervention System

July 1, 2019 – June 30, 2020

(Item 322 H.2.)

October 19, 2020

DBHDS Vision: A Life of Possibilities for All Virginians

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Virginia's Part C Early Intervention System

Preface

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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 Act 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 State Lead Agency. 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 have been allocated since FY 2015, and the General Assembly allocated a total of just over $21 million for FY 2020. Increases of $2.5 million and $3.8 million have been approved for FY 2021 and FY 2022, respectively.

In FY2020, reported expenses for the Part C early intervention system exceeded reported revenue by more than $4.2 million (6%). Other sources of data also support the overall picture of a financially-stressed early intervention service system.

- Although the total number of children served in the Part C early intervention system in FY 2020 decreased from FY 2019, data indicates there were continued increases in the child count prior to the COVID-19 public health emergency. The number of children served on March 1, 2020 was two percent higher than at that same point in 2019.

- 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.

- Twelve local systems requested additional funds totaling $1,751,714 in FY 2020. 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 $1,247,818 in FY 2020 state Part C funds allocated by the General Assembly through a caboose bill and a small amount of unallocated state funds ($78,389) were the only additional funds available and addressed about 75% of the identified need.

- The COVID-19 pandemic has had significant impacts on the Part C early intervention system, including on revenues and expenses. Overall, impacts of and flexibilities, such as telehealth, allowed during the COVID-19 pandemic likely prevented more significant budget shortfalls and definitely lessened the impacts of provider shortages.

To the maximum extent possible, the following narrative, charts and other graphics respond to the legislative requirements as delineated in Item 322.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 2020.

Revenue Source	FY20 Revenue
Medicaid, Including Targeted Case Management	$21,123,006
State Part C Funds	$20,542,275*
Local Funds	$10,240,271
Federal Part C Funds	$8,160,646*
Private Insurance and TRICARE	$5,375,296
Family Fees	$1,268,107
In-Kind	$999,201
Other State General Funds	$357,674
Grants/Gifts/Donations	$50,847

Other	$1,848,668
Total	$69,965,991

*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	$ 476,898	$200,026
Alleghany-Highlands	$ 64,948	$39,566
Arlington	$ 758,521	$313,228
Augusta-Highland	$ 201,116	$77,473
Blue Ridge	$ 650,007	$264,589
Central Virginia	$ 495,879	$198,073
Chesapeake	$ 622,242	$256,096
Chesterfield	$ 873,265	$351,559
Crater District	$ 213,408	$94,096
Cumberland Mountain	$ 119,062	$57,712
Danville-Pittsylvania	$ 194,210	$68,774
DILENOWISCO	$ 176,982	$56,038
Eastern Shore	$ 97,530	$50,477
Fairfax-Falls Church	$ 4,430,714	$1,599,528
Goochland-Powhatan	$ 161,845	$78,632
Hampton-Newport News	$ 595,326	$243,437
Hanover	$ 259,874	$115,759
Harrisonburg-Rockingham	$ 257,606	$110,965
Heartland	$ 147,394	$69,212
Henrico-Charles City-New Kent	$ 834,216	$293,378
Highlands	$ 103,763	$51,011
Loudoun	$ 1,059,975	$430,432
Middle Peninsula-Northern Neck	$ 576,223	$131,072
Mount Rogers	$ 195,804	$58,304
New River Valley	$ 341,186	$143,731
Norfolk	$ 671,005	$242,085
Piedmont	$ 128,695	$62,547
Portsmouth	$ 188,193	$86,117
Prince William, Manassas and Manassas Park	$ 871,281	$347,545

Rappahannock Area	$ 927,663	$372,654
Rappahannock-Rapidan	$ 241,457	$106,261
Richmond	$ 488,513	$196,587
Roanoke Valley	$ 389,350	$158,509
Rockbridge Area	$ 133,068	$58,644
Shenandoah Valley	$ 555,302	$177,754
Southside	$ 82,514	$44,556
Staunton-Waynesboro	$ 172,468	$54,017
Virginia Beach	$ 1,275,016	$512,853
Western Tidewater	$ 447,999	$186,244
Williamsburg-James City-York-Poquoson	$ 606,956	$228,925
Total	**$21,087,474**	**$8,188,466**

*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 2020.

Service	FY 20 Expenditure
Assessment for Service Planning	$4,062,734
Assistive Technology Devices	$28,827
Audiology	$6,385
Counseling	$5,412
Developmental Services	$5,044,690
Evaluation for Eligibility Determination	$1,556,451
Health	$113,371
Nursing	$34,085
Nutrition	$5,257
Occupational Therapy	$3,588,669
Physical Therapy	$4,352,921
Psychology	
Service Coordination	$19,177,248
Social Work	$257,986
Speech Language Pathology	$8,939,163
Transportation	$34,698
Vision	$75,085
Other Entitled Part C Services	$622,289
EI Services by Private Providers**	$15,717,801
Total-Direct Services	*$63,623,072

*The local lead agencies reported an additional $10,619,399 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 $74,242,471**.

**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

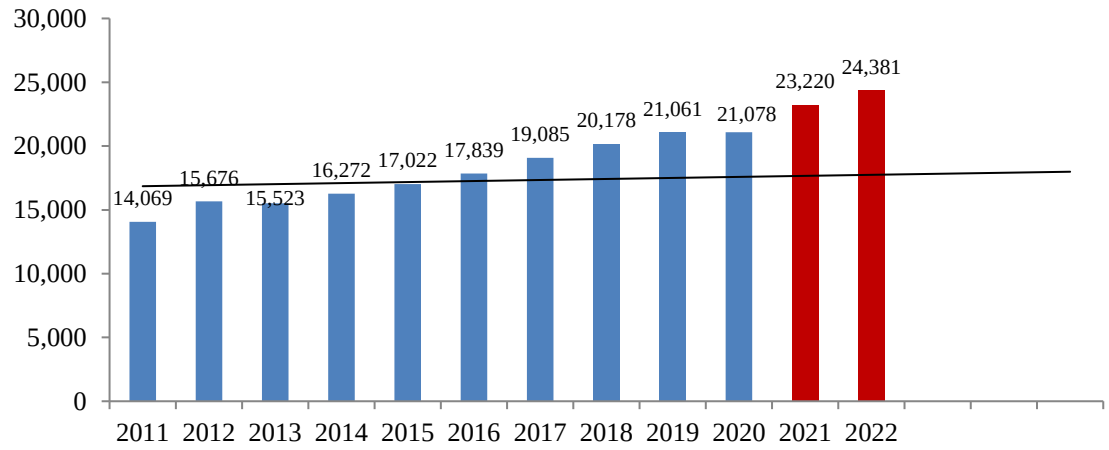
The table below shows the total number of infants and toddlers evaluated by those who were eligible and entered services and by those who did not enter services since 2004.

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
July 1, 2019 – June 30, 2020	20,178	2,419

*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.

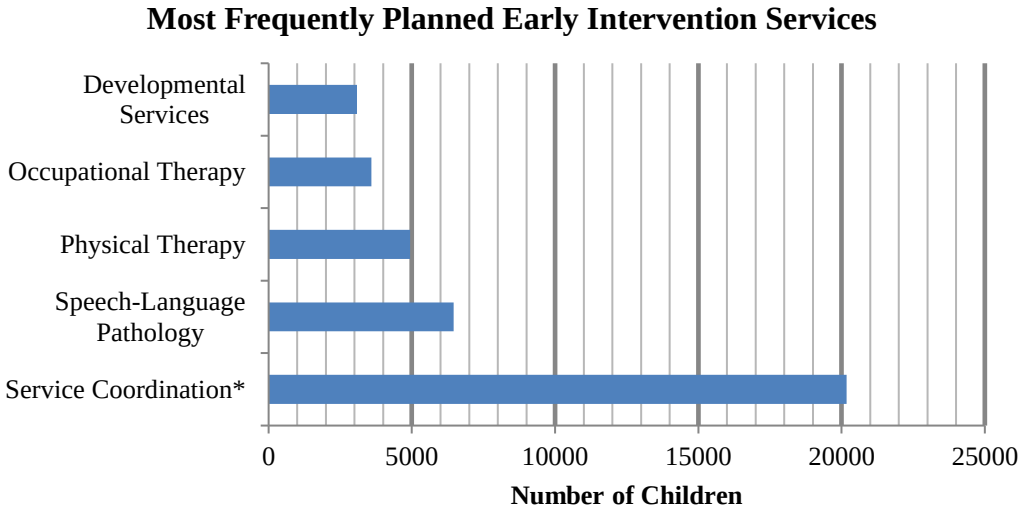
Using the total number of children served each year (annual child count), the chart below trends the projected number of eligible children served through 2022.

Annual Number Infants & Toddlers Served



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 2020.



*All eligible children receive service coordination.

FY 2020 Estimates of Total Number of Children Receiving Each Service

Type of Early Intervention Service	% of Children with an Initial IFSP* Listing that Service on 12/1/19	Estimated # of Children with an Initial IFSP Listing that Service in FY 2020 (% Multiplied
Service Coordination	100%*	20,178
Speech-Language Pathology	32.0%	6,457
Physical Therapy	24.5%	4,944
Occupational Therapy	17.8%	3,592
Developmental Services	15.3%	3,087
Audiology	0.8%	161
Vision Services	0.4%	81
Other Entitled EI Services	0.2%	40
Social Work Services	0.2%	40
Assistive Technology	0.07%	14
Nutrition Services	0.05%	10
Psychology Services	0.02%	4
Medical Services	0.01%	2
Nursing	0%	0
Counseling	0%	0
Health Services	0%	0
Psychological Services	0%	0
Sign and Cued Language 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 11,894 children received an evaluation to determine eligibility and/or an initial assessment for service planning in FY 2020.

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 getting services and includes the number of children by local system, race/ethnicity, gender, age, and the 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 exact 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 issued a request for proposals in July 2020 seeking a commercially available, off-the-shelf data system to accomplish this task and is currently reviewing vendor responses.

Overall Fiscal Climate for Part C for FY 2020 and Beyond

Reported expenses for Part C early intervention services and the critical system components that support implementation of direct services exceeded reported revenue for FY 2020 by more than $4.2 million (6%). While the completeness and accuracy of reported expense data 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, other sources of data support the overall picture of a financially-stressed early intervention service system.

- DBHDS was unable to fully meet local system needs for additional funds in FY 2020.
    - Twelve local systems requested additional funds totaling $1,751,714 in FY 2020. 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 $1,247,818 in FY 2020 state Part C funds allocated by the General Assembly through a caboose bill and a small amount of unallocated state funds ($78,389) were the only additional funds available and addressed about 75% of the identified need.
- Reported expenditures reflect the early intervention rate paid for each service, which is lower than the full cost of providing that service.
    - 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 in addition to funding shortages.

- Although diminishing overall, some Medicaid MCO reimbursement challenges continued in FY 2020. Even when the MCO reimbursement process works smoothly, it continues to require 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.

- 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. The state-level revenue shortfall compared to expenses would have been even greater if all local systems were fully staffed.

- 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.

- Due to some instances of long-standing noncompliance with federal timeline requirements resulting from fiscal challenges and/or provider shortages, Virginia dropped from the highest determination provided by the United States Department of Education (Meets Requirements) to Needs Assistance. Virginia expects to have the noncompliance corrected in the next federal reporting cycle after taking decisive action to end the contract with the local lead agency involved in the ongoing noncompliance.

- The COVID-19 pandemic has had significant impacts on the Part C early intervention system, including on revenues and expenses. Overall, impacts of and flexibilities, such as telehealth, allowed during the COVID-19 pandemic likely prevented more significant budget shortfalls and definitely lessened the impacts of provider shortages.

    - The number of children served in the Part C early intervention system in FY 2020 decreased from FY 2019, reducing expenses (as well as revenues). As of March 1, 2020, prior to the COVID-19 public health emergency in Virginia, the number of children served was two percent higher than at that same point in 2019.
    - Due to the public health emergency, Medicaid and private insurance companies agreed to allow and reimburse early intervention services delivered through telehealth and to do so at the same reimbursement rate as in-person services. Beginning in mid-March and running through the last quarter of FY 2020, most local systems delivered early intervention services only through telehealth. This resulted in cost savings since there were no travel costs associated with the telehealth service delivery.
    - Some families opted to put services on hold during the pandemic. Some families were unable to access telehealth (due to broadband access issues, limited data plans, or other technology constraints) even though providers went to extensive and creative lengths to address these kinds of access issues. These choices and limitations resulted in decreased expenses and decreased revenues.
    - A number of local systems experienced some level of Part C early intervention staff furloughs, which impacted expenses and revenue. Teleworking options for staff have provided cost savings in some local systems.

- Medicaid revenue decreased in FY 2020 for the second year in a row, down by $2 million over FY 2019. This year's lower child count and some families not receiving services during the pandemic may account for the decrease. There are also greater challenges in getting consistent revenue figures across multiple MCOs, and the reported revenue may be less accurate over the last two years than what was reported directly by DMAS during the previous fee-for-service arrangement. Since Medicaid has been the largest revenue source for Part C early intervention, the trend of annual decreases is concerning and bears close monitoring.

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 2021 initial budgets, six local systems reported a projected deficit for this year. The total projected shortfall is almost $670,000.

- Under Medicaid managed care, local lead agencies and provider agencies are

having to invest significantly more administrative time to get reimbursed than was required under the fee-for-service arrangement. Based on the revenue figures reported by DMAS, this additional investment is yielding significantly less revenue.

- 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 returning to 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;

- Urging the permanent expansion of services delivered via telehealth to include early intervention services, thereby maximizing the availability of providers and expanding access to services. DMAS allowed telehealth for early intervention during the COVID-19 public health emergency, and the benefits to children and families were clear. All local systems with previous noncompliance on timeline requirements due to provider shortages were able to correct noncompliance, ensuring children and families receive timely services. Telehealth facilitates greater flexibility in scheduling and meaningful family engagement and aligns with evidence-based early intervention practices, like caregiver coaching and functional assessment.

- Continuing 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 select a vendor to implement 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 October 1, 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 20,100 eligible infants, toddlers and their families during FY 2020. These funds also touched the lives of 2,419 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; Cities of Clifton Forge and 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, Abingdon
Loudoun County	Loudoun County
Middle Peninsula-Northern Neck	Counties of Essex, Gloucester, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, and Westmoreland; Cities of Colonial Beach and West Point
Mount Rogers	Counties of Bland, Carroll, Grayson, Smyth, and Wythe; City of Galax and 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
Crater District	Counties of Dinwiddie, Greensville, Prince George, Surry, and Sussex; Cities of Colonial Heights, Emporia, Hopewell, and Petersburg
Portsmouth	City of Portsmouth
Prince William, Manassas, Manassas Park	Prince William County; Cities of Manassas, Manassas Park and Quantico

Rappahannock Area	Counties of Caroline, King George, Spotsylvania, and Stafford; City of Fredericksburg
Rappahannock-Rapidan	Counties of Culpepper, Fauquier, Madison, Orange, and Rappahannock
Roanoke Valley	Counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson; City of Charlottesville
Richmond	City of Richmond
Blue Ridge	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; Cities of South Boston and South Hill
Augusta-Highland	Counties of Augusta and Highland
Virginia Beach	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