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November 15, 2018

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
14th Floor, Pocahontas Building,
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 312.H.2. of the *2018 Appropriation Act*, required 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,

S. Hughes Melton, MD, MBA

Enc.

Cc: The Honorable Daniel Carey, Jr.
Marvin Figueroa
Mike Tweedy
Susan Massart

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The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street
Pocahontas Building, 13th Floor
Richmond, Virginia 23219

Dear Delegate Jones:

Item 312.H.2. of the *2018 Appropriation Act*, required 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.

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Virginia Department of Behavioral Health & Developmental Services

Report on Virginia's Part C Early Intervention System

July 1, 2017 – June 30, 2018

(Item 312 H.2.)

November 15, 2018

DBHDS Vision: A Life of Possibilities for All Virginians

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Virginia's Part C Early Intervention System

Preface

Item 312.H2 of the 2018 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

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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 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 were allocated in FY 2015 – FY 2017 and the General Assembly allocated a total of $17.2 million, $18.1 million, and $19.1 million for FY 2018, FY 2019 and FY 2020, respectively.

In FY2018, reported expenses exceeded reported revenue by almost $6 million (8%). The following data underscore the picture of financial stress within the early intervention system and the importance of continued revenue growth in order to support the infants, toddlers and their families who need these critical services:

- The number of children served in the Part C early intervention system increased by almost 6% from FY 2017 to FY 2018. While the General Assembly has increased state Part C funding to support this growth, revenue from a number of other key funding sources, including federal Part C funds, local funds and family fees, have remained stagnant and revenue from non-Part C state general funds has declined.
- Increases in the number of substance exposed infants, earlier identification of autism spectrum disorders and improved statewide collaboration with Neonatal Intensive Care Units (NICUs) is expected to result in continued, and potentially even higher, annual increases in the number of children referred to and served in Virginia's early intervention system.
- Increasing costs over time have resulted in widespread reports from service providers in FY 2018 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 emerging provider shortages and, therefore, high caseloads.

- Fourteen local systems requested additional funds from DBHDS in FY 2018 in order to support the expenses of the local system, including the cost of providing services. DBHDS was able to provide the full amount needed only because of additional FY 2018 state Part C funds allocated by the General Assembly through a caboose bill and one-time additional state general funds from savings in other DBHDS programs. Savings within the Part C system covered only 29% of the additional funds needed.

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 40 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 2018.

Revenue Source	FY18 Revenue
Medicaid, Including Targeted Case Management	**$25,469,698**
State Part C Funds	**$18,642,543***
Local Funds	**$10,533,071**
Federal Part C Funds	**$9,205,934***
Private Insurance and TRICARE	**$6,011,479**
Family Fees	**$989,423**
In-Kind	**$877,142**
Other State General Funds	**$414,113**
Grants/Gifts/Donations	**$26,574**
Other	**$1,335,988**
Total	**$73,505,965**

*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 40 local lead agencies:

Funds Allocated by Local Lead Agency*

Infant & Toddler Connection of:	State	Federal
Alexandria	$ 418,917	$ 213,467
Alleghany-Highlands	$ 65,995	$ 43,400
Arlington	$ 735,868	$ 367,956
Augusta-Highland	$ 112,482	$ 65,482
Blue Ridge	$ 541,979	$ 263,441
Central Virginia	$ 397,594	$ 166,586
Chesapeake	$ 636,948	$ 318,521
Chesterfield	$ 616,864	$ 306,501
Crater District	$ 234,093	$ 81,399
Cumberland Mountain	$ 94,309	$ 54,711
Danville-Pittsylvania	$ 213,405	$ 70,564
DILENOWISCO	$ 88,590	$ 50,235
Eastern Shore	$ 79,678	$ 48,561
Fairfax-Falls Church	$ 3,474,558	$2,109,045
Goochland-Powhatan	$ 96,407	$ 58,942
Hampton-Newport News	$ 475,519	$ 237,548
Hanover	$ 184,838	$ 100,414
Harrisonburg-Rockingham	$ 199,136	$ 94,624
Heartland	$ 141,037	$ 76,858
Henrico-Charles City-New Kent	$ 647,597	$ 317,733
Highlands	$ 116,330	$ 66,522
Loudoun	$ 868,108	$ 412,654
Middle Peninsula-Northern Neck	$ 544,518	$ 119,694
Mount Rogers	$ 131,937	$ 72,202
New River Valley	$ 217,228	$ 113,558
Norfolk	$ 474,526	$ 214,866
Piedmont	$ 83,032	$ 50,200
Portsmouth	$ 240,275	$ 78,851
Prince William, Manassas and Manassas Park	$ 778,880	$ 381,770
Rappahannock Area	$ 785,308	$ 387,171
Rappahannock-Rapidan	$ 243,071	$ 127,867
Richmond	$ 387,635	$ 192,560
Roanoke Valley	$ 360,096	$ 178,526
Rockbridge Area	$ 86,385	$ 51,839
Shenandoah Valley	$ 502,942	$ 181,493
Southside	$ 97,008	$ 48,301
Staunton-Waynesboro	$ 125,181	$ 61,541
Virginia Beach	$ 1,035,637	$ 510,473
Western Tidewater	$ 330,806	$ 167,684
Williamsburg-James City-York-Poquoson	$ 516,368	$ 226,396
Total	**$17,381,085**	**$8,690,156**

*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 2018.

Service	FY 18 Expenditure
Assessment for Service Planning	$3,730,727
Assistive Technology Devices	$36,787
Audiology	$14,677
Counseling	$12,466
Developmental Services	$4,064,415
Evaluation for Eligibility Determination	$1,359,710
Health	$106,842
Nursing	$26,229
Nutrition	$18,129
Occupational Therapy	$2,922,962
Physical Therapy	$3,193,058
Psychology	$0
Service Coordination	$16,534,383
Social Work	$197,311
Speech Language Pathology	$10,967,121
Transportation	$134,650
Vision	$78,603
Other Entitled Part C Services	$608,102
EI Services by Private Providers**	$24,928,505
Total-Direct Services	$68,934,677*

*The local lead agencies reported an additional $10,455,883 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 $79,390,560**.

**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.

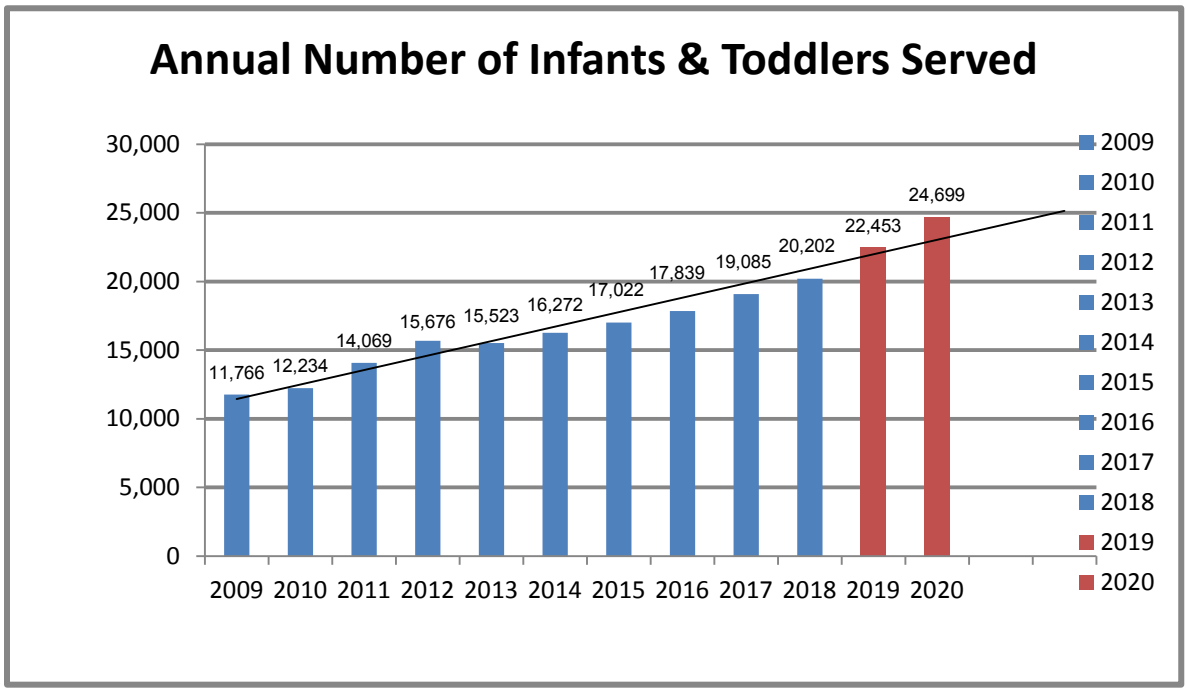
Total Number of Infants and Toddlers Served

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

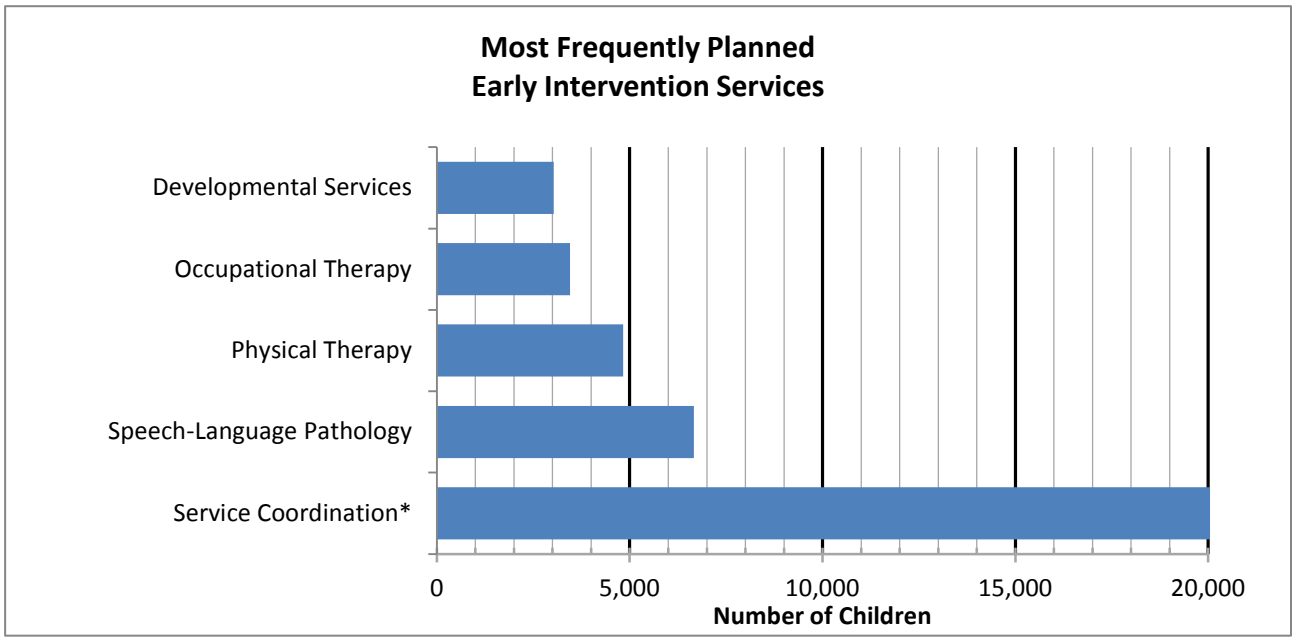
*These children received a multidisciplinary team evaluation to determine eligibility and, in some cases, an assessment for service planning, but did not enter services because they were either found ineligible for Part C, declined Part C early intervention services, or were lost to contact. Since evaluation 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 2020.



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 2018.



*All eligible children receive service coordination.

FY 2018 Estimates of Total Number of Children Receiving Each Service

Type of Early Intervention Service	% of Children with an Initial IFSP* Listing that Service on 12/1/17	Estimated # of Children with an Initial IFSP Listing that Service in FY 2018 (% Multiplied by Total Served)
Service Coordination	100%*	20,202
Speech-Language Pathology	33.0%	6,667
Physical Therapy	23.9%	4,828
Occupational Therapy	17.1%	3,455
Developmental Services	15.0%	3,030
Vision Services	0.80%	162
Audiology	0.70%	141
Social Work Services	0.30%	61
Other Entitled EI Services	0.20%	40
Assistive Technology	0.09%	18
Nutrition Services	0.05%	10
Medical Services	0.02%	4
Psychological Services	0.01%	2
Nursing	0.01%	2
Counseling	0%	0
Health Services	0%	0

Sign Language & 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 13,370 children received an evaluation to determine eligibility and/or an initial assessment for service planning in FY 2018.

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 has begun developing a data system solution to accomplish this task. Development is proceeding slowly and is expected to take another one to two years.

Overall Fiscal Climate for Part C for FY 2018 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 2018 by almost $6 million (8%). While 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, other sources of data support the overall picture of a financially-stressed early intervention service system.

- 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, which are estimated at $175 per month, based on a cost study conducted by DMAS in 2008 and updated in 2009. Given that the cost study is nine years old, it likely underestimates the cost of providing service coordination.

- 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, for the first time, many early intervention service providers statewide reported in FY 2018 that these early intervention rates that were set in 2009 no longer cover their cost for providing these services. Reported expenditures in this report reflect the early intervention rate paid for each service, which may be lower than the full cost of providing that service.

- The transition of the Medicaid Early Intervention Program from fee-for-service to managed care starting in FY 2018 has resulted in significant financial hardships for many early intervention providers. These challenges are continuing in 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 and continue to receive 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 are widespread instances 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, the 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.

- The number of children served in the Part C early intervention system increased by almost 6 percent from FY 2017 to FY 2018. This follows a 7 percent increase in child count in FY 2017 and approximately 5 percent annual increases in other recent years. While the General Assembly has increased state Part C funding to support this growth, revenue from a number of other key funding sources, including federal Part C funds, local funds and family fees have remained stagnant and revenue from non-Part C state general funds declined about 2 percent from FY 2017 to FY 2018.

- Fourteen local systems requested additional funds in FY 2018. This is a significant increase over the nine local systems that requested additional funds in FY 2017. The funds were needed to support the expenses of the local system, including the cost of providing services. Although DBHDS was able to provide the fourteen local systems requesting additional funds in FY 2018 with the full amount needed, only 29 percent of that funding was from savings in state-level use of federal Part C funds. Additional FY 2018 state Part C funds allocated by the General Assembly through a caboose bill and one-time additional state general funds from savings in other DBHDS programs were the only reason these budget shortfalls could be fully addressed.

- In order to operate within available funding or to minimize budget shortfalls, local systems use 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. While these strategies assist local systems to ensure services for all eligible children and families 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.

- A number of local systems reported provider shortages during FY 2018. In some instances provider shortages resulted in infants, toddlers and their families experiencing 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. These delays impact not only individual children and families but also Virginia's ability to comply with federal timeline requirements. Anecdotal reports indicate that, while shortages are common 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 the Part C early intervention system. Provider shortages are leading to high caseloads, which, in turn, contribute to the workforce challenges and potentially impact the quality of services provided.

- When submitting their FY 2019 initial budgets, ten local systems reported a projected deficit for this year. The total projected shortfall is over $1.5 million.

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

- An increase in the number of substance exposed infants. Data from the Virginia Hospital and Health Care Association indicated an 11% increase from 2016 to 2017 in the total number of children born in Virginia hospitals with Neonatal Abstinence Syndrome (NAS). This data only partially illustrates the scope of the issue. Counting children with a diagnosis of NAS accounts for only some of the children who are automatically eligible for early intervention under Virginia's definition of toxic exposure. In addition, this data does not account for those children who are substance exposed prenatally, do not show immediate effects or have a diagnosis of NAS but could, based on current research, benefit from early intervention if there was

additional funding available to expand Virginia's eligibility to include these infants and their families;

- Earlier identification of autism spectrum disorders with a potential need for more intensive and frequent services;

- Continued increases in referrals from Neonatal Intensive Care Units as a positive result of a Virginia Board for People with Disabilities (VBPD) funded grant to the VA Hospital and Healthcare Association;

- Expected increases in referrals from Medicaid Managed Care Organizations as a positive result of including Early Intervention Part C services in managed care; and

- Federal early intervention requirements that 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 falling into 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. To this end, DBHDS continues to:

- Closely monitor the fiscal situation across local systems;

- Provide 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;

- Work collaboratively with the Department of Medical Assistance Services (DMAS) and local systems to address reimbursement challenges as Part C Early Intervention Services are folded into Medicaid managed care ;

- Explore with DMAS the use of telehealth practices to deliver early intervention services, thereby maximizing the availability of providers and expanding access to services;

- Use savings from other DBHDS programs to support direct early intervention services and/or professional development that supports those services, to the extent possible. In FY 2018, DBHDS awarded one-time additional state general funds to help address local budget shortfalls, fully support the cost for twenty-five early interventionists to pursue Infant Mental Health Endorsement, and train up to forty early interventionists on the

Ages and Stages Questionnaire-Social Emotional screening tool; and

- Work to fund and develop a comprehensive early intervention data system that will collect delivered service and non-duplicated revenue and expenditure data.

Consultation with national fiscal experts confirms that DBHDS is taking all reasonable fiscal management actions given the current data available and that a more comprehensive data system is essential to truly ensure effective state and local fiscal management and oversight.

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 20,200 eligible infants, toddlers and their families during FY 2018. These funds also touched the lives of 2,150 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 W estmoreland; 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