COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 29, 2022

MEMORANDUM

TO: The Honorable Janet Howell
Co-Chair, Senate Finance and Appropriations Committee

The Honorable George Barker
Co-Chair, Senate Finance and Appropriations Committee

The Honorable Barry D. Knight
Chair, House Appropriations Committee

Michael Maul
Director, Virginia Department of Planning and Budget

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Review of Medicaid and FAMIS Dental Benefits

This report is submitted in compliance with item 304.IIII.2. of the 2022 Appropriations Act, which states:

"The Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, shall review Medicaid and FAMIS dental benefits to determine any issues related to access. The department shall report its findings to the Chairmen of the House Appropriations and Senate Appropriations and Finance Committees and the Director, Department of Planning and Budget by October 15, 2022."

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CR
Enclosure

Pc: The Honorable John Littel., Secretary of Health and Human Resources

A Review of Medicaid and FAMIS Dental Benefits to Determine Any Issues Related to Access

A Report to the Virginia General Assembly and the Director of the Department of Planning and Budget

November 29, 2022

Report Mandate:

Item 304.IIII.2 of the 2022 Appropriations Act states "The Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, shall review Medicaid and FAMIS dental benefits to determine any issues related to access. The department shall report its findings to the Chairmen of the House Appropriations and Senate Appropriations and Finance Committees and the Director, Department of Planning and Budget by October 15, 2022."

The Department wishes to thank the General Assembly for increasing dental rates by 30% on July 1, 2022.

Background

Dental Program Structure

Prior to 2005, the Department's contracted Managed Care Organizations (MCOs) administered the dental benefits for the majority of Virginia's Medicaid and Family Access to Medical Insurance Security (FAMIS) members. The Department administered the dental benefits for those members enrolled in the fee-for-service program. Virginia's dental provider community had expressed dissatisfaction with various aspects of the program's structure and administration, leading to low provider participation rates. In early 2005, there were only 620 participating dentists and fewer than 50% were treating Medicaid/FAMIS patients.

DMAS worked closely with the dental provider community and other oral health advocates to revamp the dental program to make it more responsive for providers and offer greater access to care for Medicaid/FAMIS members. On July 1, 2005, the Department restructured the dental benefits program by carving dental services out of the MCOs and contracting with a single dental benefits administrator (DBA). The DBA, paid through an administrative services only (ASO) model, became responsible for managing the dental benefits for all Medicaid/FAMIS members, including those enrolled in an MCO. In addition to the administrative restructuring, the General Assembly authorized a 30% increase in dental fees which was implemented in two phases, 28% on July 1, 2005, and the remaining 2% on May 1, 2006.

As children were the only Medicaid/FAMIS members receiving comprehensive dental services at the time, the new dental program was rebranded as "***Smiles For Children***." An extensive statewide provider recruitment effort was undertaken to make providers aware of the new structure and fee schedule. Concurrently, oral health and dental care were receiving greater attention across Virginia and the nation. As a result, provider participation in the program doubled by 2012 and the percentage of participating dentists treating Medicaid/FAMIS patients increased to 80%.

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.

Increased provider availability, along with concerted oral health advocacy by DMAS and its partners, led to significant increases in utilization of services by children.

Following the dental fee increase authorized in 2005, there were no other increases in reimbursement until 2022. During this 17-year period, the "market value" of the 2005 rate increase gradually eroded and the ***Smiles For Children*** rates fell further behind private insurance reimbursement.

Provider Surveys Indicate Overall Satisfaction with the Administration of the Smiles For Children Program

The DBA, DentaQuest, has served as the dental benefits administrator since the inception of the ***Smiles For Children*** program. Annual provider surveys consistently show the program to be viewed favorably by dentists. In the 2021 survey responses, 82% of survey respondents indicated they are satisfied. Also, 95% of participating dentists stated the program is as good as or better than competitor dental insurance carriers.

In 2010 the ***Smiles For Children*** program was selected by the Centers for Medicare and Medicaid Services as one of eight innovative Medicaid dental programs in the nation and has served as a model for other states.

Comprehensive Dental Benefits Were Extended to Pregnant Members and Other Adults

Because dental services are a mandated benefit for children under the Children's Health Insurance Program (CHIP) and the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) provisions of Medicaid, dental has always been a covered benefit for children. In contrast, dental is an optional benefit for pregnant members and adults in Medicaid.

Based on the evidence of the importance of oral health to overall health, Virginia added comprehensive dental benefits for pregnant members on March 1, 2015, and for all other adults on July 1, 2021. Prior to these dates, pregnant members and other adults received limited dental services (i.e. primarily extractions).

Defining "Access to Care"

The language in the Appropriations Act Item 304.IIII.2 directs DMAS to "review Medicaid and FAMIS dental benefits to determine any issues related to access". This study analyzes the availability of providers and other issues that may need to be addressed to ensure access to care such as: (i) utilization patterns, (ii) adjustments to the benefits, (iii) refinements to how certain services are paid and the level of reimbursement, and (iv) other factors that may impact members' access to dental services.

Having enough providers available to treat covered members is a crucial component of "access." Yet "access" also includes other factors which must be in place to ensure patients receive necessary and quality care. These include having sufficient insurance coverage, making certain specific services are offered by available providers and are covered by insurance, addressing social determinants of health, ensuring timeliness of care, and removing other impediments to receiving treatment.

Organization of Report

The remainder of this report is presented in the following major sections:

- Stakeholder Engagement Process
- Current Provider Availability and Its Impact on Access to Care
- Potential Benefit and Reimbursement Modifications to Improve Access to Care
- Other Potential Medicaid/FAMIS Program Actions to Improve Access to Care
- DMAS Actions and Recommendations

Stakeholder Engagement Process

As directed by the Appropriations Act, DMAS conducted this study in collaboration with appropriate stakeholders. Figure 1 identifies the 17 stakeholder groups DMAS contacted and solicited input into this study.

Each stakeholder group was contacted by email and encouraged to provide input regarding any access to care issues and potential actions to remedy the concern. Follow-up emails were sent if needed. Stakeholder input consisted of both written submissions and virtual meetings with DMAS representatives. Overall, the stakeholders provided useful feedback on access issues and suggestions for making improvements.

Figure 1
Stakeholders Contacted by DMAS To Provide Input into the Study

- DMAS' Dental Advisory Committee
- Virginia Health Catalyst
- Old Dominion Dental Society
- Virginia Dental Association

VIRGINIA'S MEDICAID PROGRAM DMAS

- Virginia Dental Hygienists Association
- Virginia Commonwealth University School of Dentistry
- Ad-Hoc Committee on Dental Fees*
- Virginia Department of Health (Dental Health Program)
- Virginia Department of Behavioral Health & Disability Services (Office of Integrated Health)
- Virginia Health Care Foundation
- Virginia Health Care Association
- Virginia Association of Community Services Boards
- Virginia Community Healthcare Association
- Virginia Board for People with Disabilities
- Benevis/Pine & Spencer Dental Teams
- Virginia Network of Private Providers
- Families Forward

* The Ad-Hoc Committee on Dental Fees was convened to assist DMAS in implementing the 30% fee increase authorized in 2022. The Committee included 21 representatives of various dental specialties and dental hygienists.

Current Provider Availability and Its Impact on Access to Care

Virginia's Dentistry Workforce and Its Participation in the Smiles For Children Program

As seen in Figure 2, the number of dentists participating in the ***Smiles For Children*** program steadily increased from 1,092 in FY2010 to 1,929 in FY2018; a 76.6% increase. Since FY2018, participation has declined to 1,782 in FY2022; a 7.6% decrease from FY2018. In spite of the downward trend in participation over the last few years, the DBA reports that approximately 100 new dentists have joined the network between July and August 2022. Additionally, outreach to non-participating providers is underway, including information about the recent 30% increase in reimbursement rates. While the provider network has increased over the years, it important to note that some dentists continue to express hesitancy to join the network to provide care to Medicaid members because of the complexity of medical conditions and perceived difficulty of caring for the population's needs.

The Department of Health Professions indicates that as of 2021, 5,857 dentists worked at least an hour in some capacity in a city or county in Virginia and 4,589 dentists worked a traditional FTE of 40 hours per week. With the 30% increase, the Department views this as an opportunity to expand the dental provider network. It should also be recognized that the free clinics and Federally Qualified Health Centers (FQHCs) have added providers and expanded capacity to provide dental care to Medicaid members as a result of the increased reimbursement.

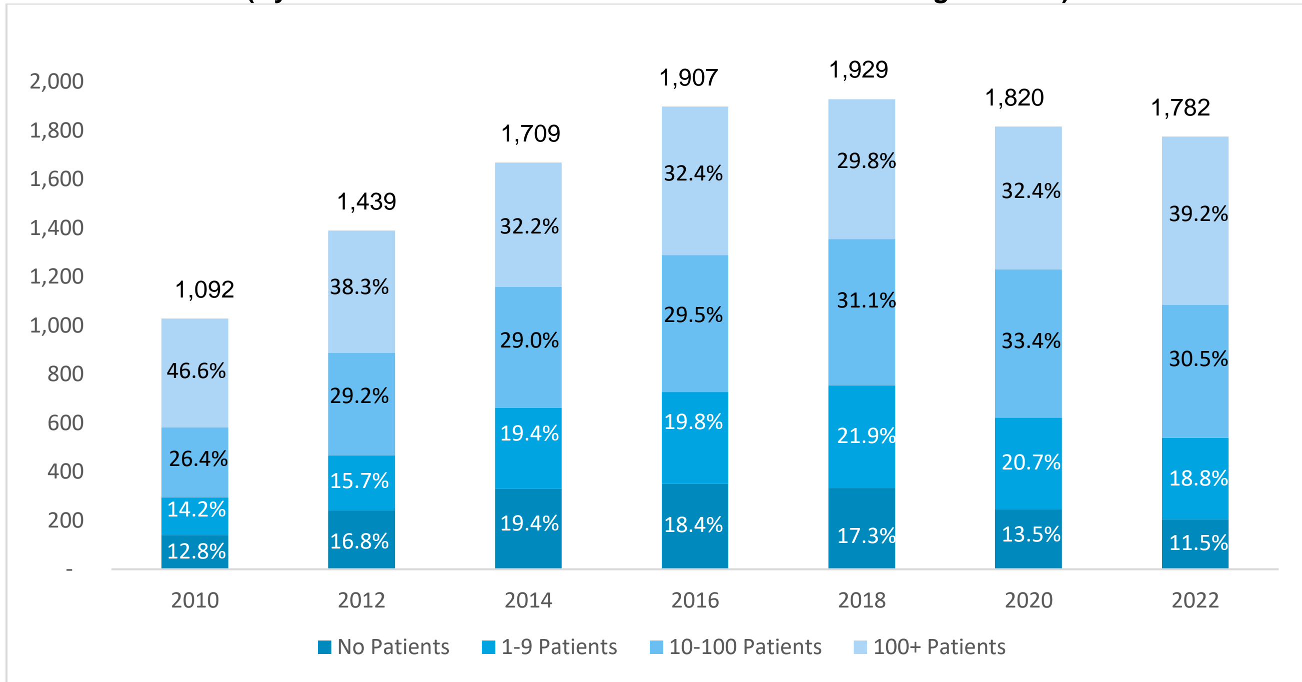
Figure 2 depicts the percentage of participating providers who treat varying numbers of Medicaid/FAMIS patients. For FY2022, 39.2% of ***Smiles For Children*** dentists treated 100+ Medicaid/FAMIS patients, which represents the largest subgroup of participating dentists; 30.5% treated 10-100 Medicaid/FAMIS patients; 18.8% treated 1-9 Medicaid/FAMIS patients; and 11.5% did not treat any Medicaid/FAMIS patients. The percentage of participating dentists who do not provide services to Medicaid/FAMIS patients has declined in recent years from 19.4% in SFY 2014 to 11.5%, or 205 participating dentists, in FY2022.

Dentists' Participation in *Smiles For Children* as a Percentage of Virginia's Overall Dentistry Workforce

The Department of Health Professions (DHP) publishes "Virginia's Dentistry Workforce", an annual report which contains various demographic information regarding licensed dentists in Virginia. The DHP report provides a count of all dentists licensed in Virginia as well as another count of dentists designated as Virginia's "Dentistry Workforce." This is defined in the 2021 report as "*A licensee with a primary or secondary work site in Virginia at any time between April 2020 and March 2021 or who indicated intent to return to Virginia's workforce at any point in the future.*" DMAS uses this estimate in the following analyses.

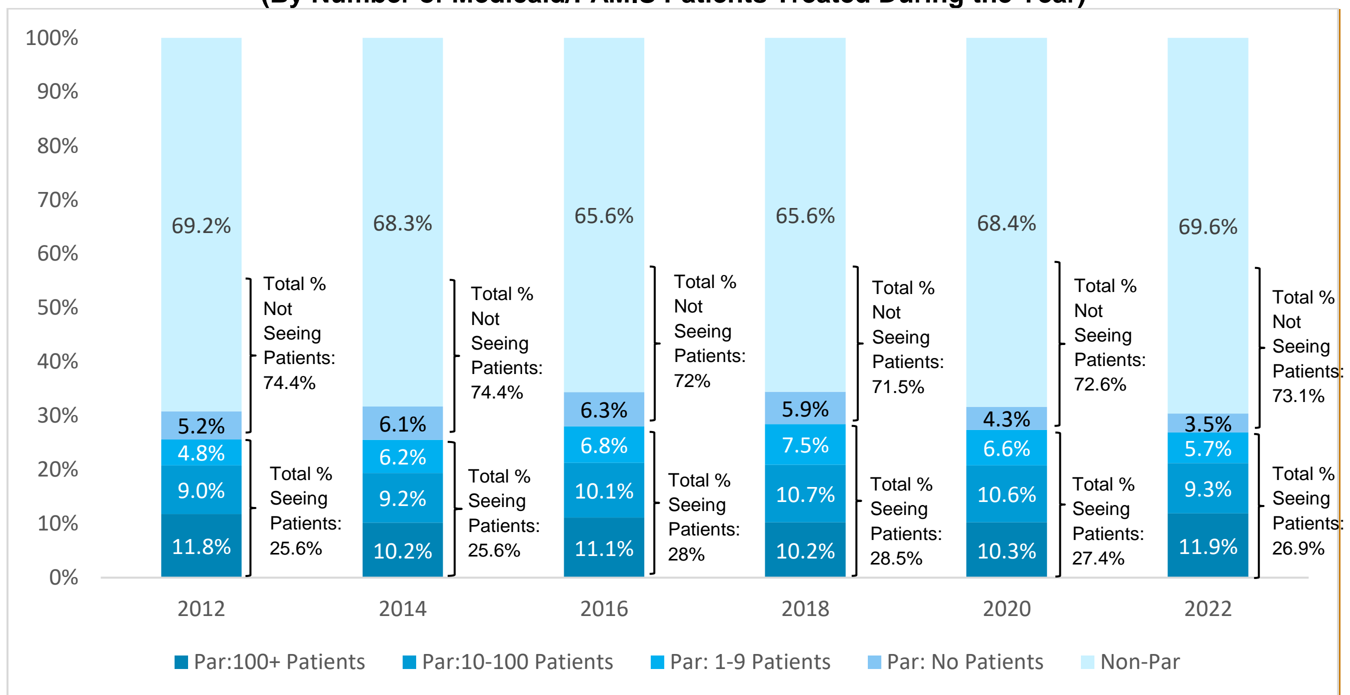
Figure 3 illustrates that in FY2022, 26.9% of Virginia's dentistry workforce treated Medicaid/FAMIS members. The remaining 73.1% of Virginia's dentistry workforce did not treat any Medicaid/FAMIS patients. This includes 3.5% who participate in ***Smiles For Children*** but did not treat any Medicaid/FAMIS patients, and 69.6% who do not participate in the program. (DBA sends a notice every six months to participating providers who have not submitted any claims during the period and encourages them to treat Medicaid/FAMIS patients.)

Figure 2
Total Number of Dentists Participating in the *Smiles For Children* Program
(By Number of Medicaid/FAMIS Patients Treated During the Year)



Source: DentaQuest: ***Smiles For Children*** provider participation and claims submission data
Note: Years are State Fiscal Years. Percentages represent the number of providers treating: No patients, 1-9 patients, 10-100 patients, and 100+ patients. Percentage totals may not add due to rounding.

Figure 3
Percentage of Virginia's Dentist "Workforce" Treating Medicaid/FAMIS Patients
(By Number of Medicaid/FAMIS Patients Treated During the Year)



Source: DentaQuest: *Smiles For Children* provider participation and claims submission data; Virginia Department of Health Professions: "Virginia's Dentistry Workforce" reports

Note: Years represent State Fiscal Years. "Par:" = Participating in *Smiles For Children* program*;* "Non-Par:" = dentists who do not participate. Percentage totals may not add due to rounding. The Virginia Dentistry Workforce Report for 2022 had not been released prior to this study. The 2021 Workforce Report was used for FY2022

Dentists Participating in *Smiles for Children* by Region

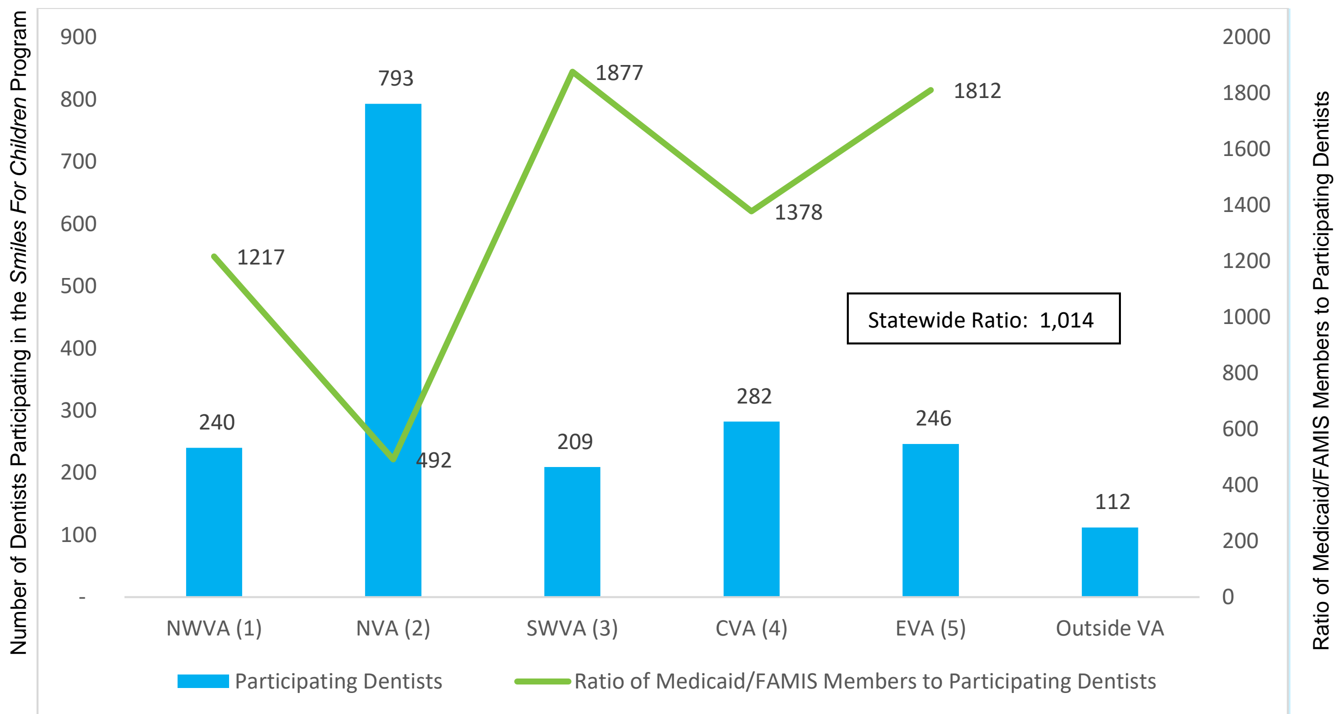
Figure 4 presents data on the number of dentists participating in the ***Smiles For Children*** program in each region of the Commonwealth as of August 2022, including any who did not treat Medicaid/FAMIS patients in FY2022. (A listing of the counties and cities that make up each region is provided in Appendix A.)

Northern Virginia has the most participating dentists with 793; Southwest Virginia had the fewest number of participating dentists with 209. Part of the reason there are so few participating providers in Southwest VA and other rural areas is the limited availability of providers in the area to recruit for the ***Smiles For Children*** program. DHP's "Virginia Dentistry Workforce" report for 2021 noted that only 7% of dentists currently work in non-metro areas of the state.

Figure 4 also includes a ratio of Medicaid/FAMIS members per participating dentists in each region. Northern Virginia had the lowest ratio, with 492 Medicaid/FAMIS members per participating dentist. Southwest Virginia had the highest ratio with 1,877 members per dentist, followed by Eastern Virginia with a ratio of 1,812. The statewide ratio was 1,014.

Figure 5 identifies the number of practice locations by specialty across the five regions. Similar to the overall participation of dentists by region portrayed in Figure 4, Southwest Virginia has the smallest number of ***Smiles For Children*** practice locations (345) and Northern Virginia has the most (1,139). The number of practice locations is greater than the number of individual/unique providers due to some dentists having multiple offices.

Figure 4
Number of Dentists Participating in the *Smiles For Children* Program By Region and Ratio of Medicaid/FAMIS Members Per Participating Dentist (August 2022)



Source: DBA: *Smiles For Children* provider participation as of August 2022; Medicaid/FAMIS member data for FY2022.
Note: Number of dentists are those participating in *Smiles For Children*; the number treating patients is not designated here. "Outside VA" dentists are those with a practice location outside of Virginia but participate in the *Smiles For Children* program.

Figure 5
Practice Locations Participating in *Smiles For Children* by Specialty and Region

Dental Specialties	Regions				
	NWVA (Region 1)	NVA (Region 2)	SWVA (Region 3)	CVA (Region 4)	EVA (Region 5)
Anesthesiologist	16	2	30	23	33
Endodontist	2	15	4	2	3
General Practitioner	329	809	241	266	318
Oral Surgeon	47	45	18	28	24
Orthodontist	57	98	20	69	48
Pediatric Dentist	53	141	24	71	141
Periodontist	4	20	5	3	1
Prosthodontist	0	9	3	0	0
Other*	0	0	0	3	0
TOTAL	503	1,139	345	465	568

Source: DBA: *Smiles For Children* provider participation data as of June 30, 2022;
Notes: This table indicates the number of practice "locations" by specialty which is greater than the number of individual dentists. Not every practice location listed in this table is necessarily treating Medicaid/FAMIS patients.
* Other: 1 Denturist and 2 Oral Pathologists in CVA

The American Dental Association's Health Policy Institute (ADA-HPI) Reported in 2021 That the Percentage of Licensed Dentists in Virginia Treating Any Medicaid Patients is Next to Last Among 41 States Included in its Analysis

An ADA-HPI report released in October 2021 analyzed the percentage of licensed dentists in each state who were enrolled as a Medicaid provider as well as the percentage who treated various numbers of Medicaid patients. The ADA-HPI analysis was based on 2017 claims data and reflected the experiences of 41 states for which data were available. While the methodology used by ADA-HPI is similar to that used by DMAS and described earlier, there are differences. A key element of the ADA-HPI analysis is the availability of comparative data across states, which provides useful benchmarking data.

As illustrated in Figure 6, the ADA-HPI data show that the percentage of licensed dentists participating or enrolled as a Medicaid provider ranged from a low of 13% in New Hampshire to 89% in Iowa, with the average percentage being 45.7%. Virginia's participation rate of 29% was well below the national average.

Additionally, the ADA-HPI analysis found that the percentage of licensed dentists enrolled in Medicaid but not treating any Medicaid patients was 18% for Virginia, which is higher than the 13.1% nationwide average. The nationwide range was from 2% in New Hampshire to 29% in Utah.

Lastly, the report calculated an overall percentage of licensed dentists in each state who were enrolled providers treating any number of Medicaid/FAMIS patients. Virginia was next to last among the 41 states included in the study, with 11% of licensed dentists who were enrolled and treating Medicaid/FAMIS patients. The breakout of Virginia's 11% figure is as follows: 1-9 patients (1%); 10-100 patients (5%) and 100+ patients (5%).

The ADA-HPI data indicate 89% of licensed dentists in Virginia saw no Medicaid/FAMIS patients for the time period examined during the study (i.e., 71% who do not

participate in the program and an additional 18% who participate in the program, but do not see any patients).

ADA-HPI also Analyzed Dentist Participation in Medicaid as it Relates to the Ratio of Medicaid-to-Private Insurance Payment Rates

As documented in numerous studies, reimbursement has long been considered a chief determinant of dentists' willingness to participate in Medicaid. While comparing Medicaid dental reimbursement between states can be a useful state-to-state analysis, dentists' decisions on whether to participate in Medicaid and treat Medicaid patients are driven more by how Medicaid rates compare to private/commercial dental insurance reimbursement. Rates that are far below private insurance reimbursement make it more difficult for dentists to participate in Medicaid and, more importantly, treat Medicaid patients.

The ADA-HPI study included an analysis of dentists' participation in Medicaid and the number of patients they treat as compared to the level of Medicaid reimbursement. Medicaid reimbursement was measured as a percentage of private payment rate.

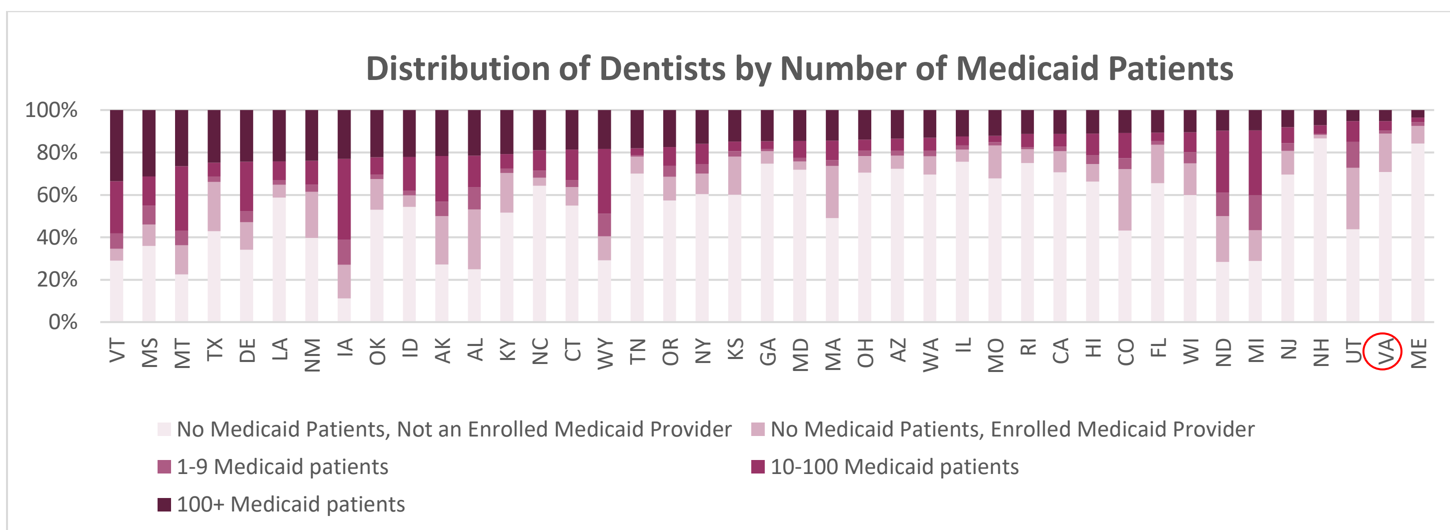
Figure 7 presents the findings of the ADA-HPI analysis of the percentage of participating dentists treating any number of patients versus Medicaid reimbursement in each state. Virginia's percentage of participating dentists treating any number of patients (11%) is quite low compared to other states, given the 2020 reimbursement level of 63.7% of private payment rate. Based on the participation trendline (red dotted line in graphic), Virginia's percentage of dentists treating any Medicaid patients would be expected to be closer to 32-33%.

Factoring in the 30% increase in dental fees authorized in July 2022, Virginia's Medicaid-to-private insurance ratio is approximately 82% to 83%. Any increases in private insurance reimbursement since the ADA-HPI analysis will offset the increase in the ratio.

The Number of "Actively Participating" Dentists Treating Medicaid/FAMIS Patients is a More Informative Measurement

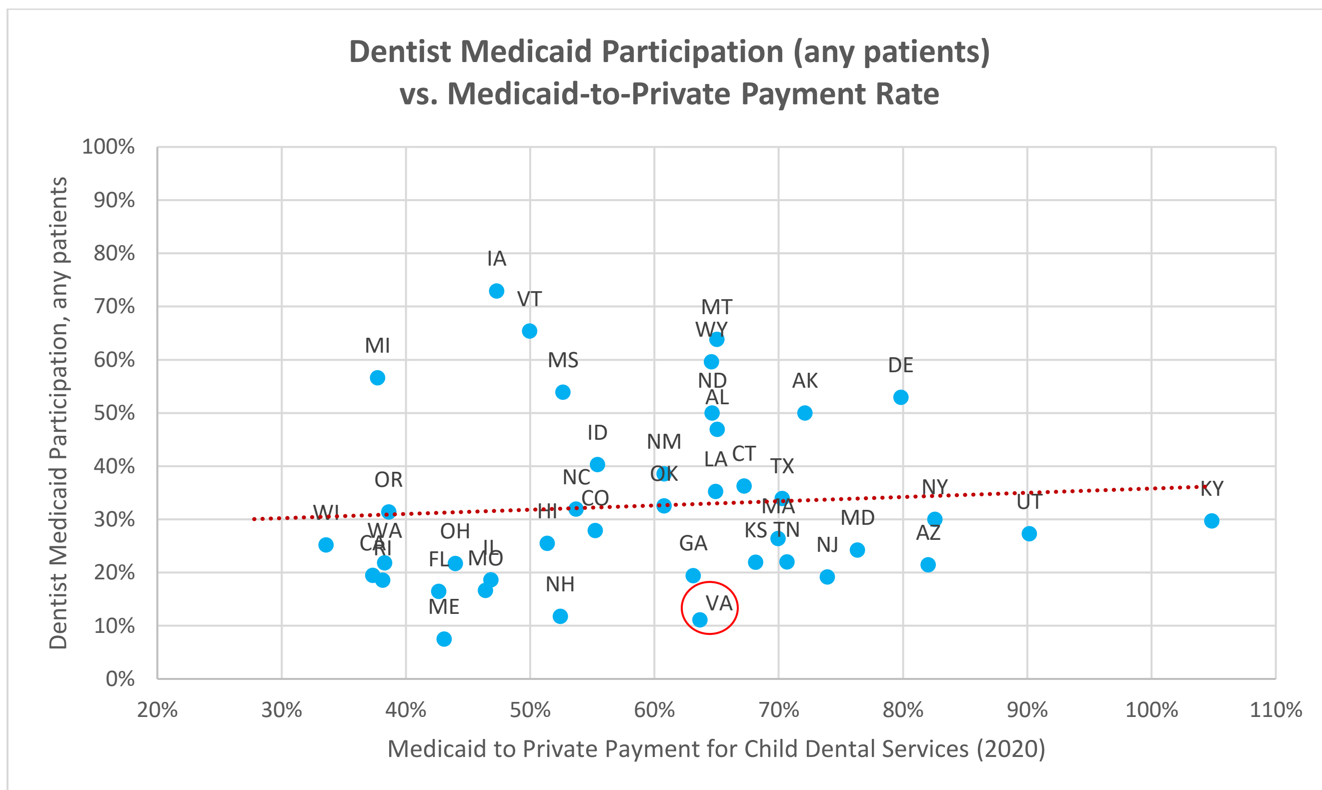
The number of providers participating in Medicaid or any insurance program is often used to measure the capacity of a provider network. However, as seen in Figures 3, 6 and 7, the number of dentists participating or enrolled in Medicaid programs does not necessarily reflect the number of providers actually treating Medicaid/FAMIS patients. Moreover, as the 30% payment increase occurred in July, the Department cannot provide an analysis on the long term impact of the increase on the provider network. A more accurate method for assessing provider availability in the ***Smiles For Children*** program would be to track the number of actively participating dentists who are treating Medicaid/FAMIS members over the next 12 months.

Figure 6
American Dental Association's Health Policy Institute (ADA-HPI) Graphic on Distribution of Dentists by Number of Medicaid Patients



Note: Virginia's percentages are: No Medicaid Patients, Not an Enrolled Medicaid Provider (71%), No Medicaid Patients, Enrolled Provider (18%), 1-9 Medicaid Patients (1%), 10-100 Medicaid Patients (5%), and 100+ Medicaid Patients (5%). Percentage of dentists treating any Medicaid patients (11%)
Source: American Dental Association-Health Policy Webinar, October 2021, Insights on Medicaid Programs | American Dental Association (ada.org)

Figure 7
ADA-HPI Graphic on Medicaid Participation & Reimbursement Levels



Source: American Dental Association-Health Policy Webinar, October 2021, [Insights on Medicaid Programs | American Dental Association (ada.org)]
Note: Virginia's data points: Percentage of dentists treating any Medicaid patients (11%); Medicaid to Private Payment for Child Dental Services (63.7%)

There Have Been Significant Increases in the Number of Medicaid Members with Dental Benefits Who Now Are Seeking Care

Access to dental care is not just a function of how many providers there are (i.e., supply), but also the number of patients seeking care (i.e., demand). In Virginia, the number of Medicaid members with comprehensive dental benefits has increased considerably in the past three years. The total number of members in the Medicaid/FAMIS program increased from 1.22 million in December 2018 to 2.06 million in August 2022, all of whom now receive comprehensive dental benefits. Figure 8 illustrates Medicaid/FAMIS enrollment by category of eligibility.

The combined effect of three major program events has led to this increase: (i) implementing Medicaid expansion on January 1, 2019; (ii) adding comprehensive dental benefits for all Medicaid adults on July 1, 2021; and (iii) suspending eligibility redeterminations as required by the maintenance of effort provisions of the federal Families First Coronavirus Response Act (FFCRA).

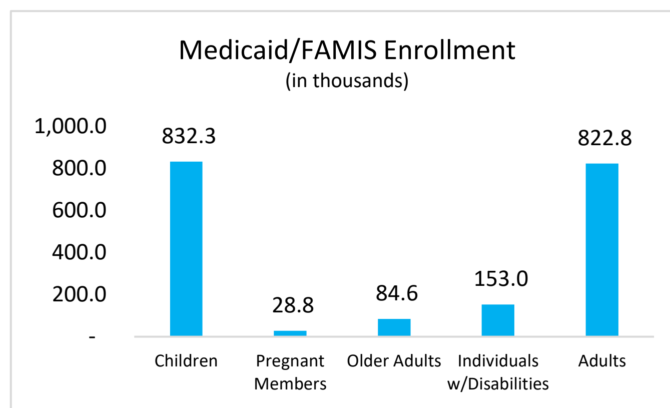
Virginia's expansion of its Medicaid program under the Affordable Care Act (ACA) increased the income eligibility level of caretaker adults to 138% of the federal poverty level (FPL) and expanded the program to include childless adults. Prior to

the addition of comprehensive dental benefits for adults in 2021, these members were eligible only for limited care, essentially extractions. Adult members often had to resort to hospital emergency departments or rely on free/charitable sources of care. Persons not able to access necessary dental services often see a decline in overall health, experience worsened chronic health conditions, and incur higher medical costs[1].

The suspension of eligibility redeterminations during the COVID-19 Public Health Emergency (PHE) has further contributed to enrollment growth in Virginia and across the nation. Once the PHE ends, states will need to re-start eligibility redeterminations, which will result in some members losing their Medicaid benefits. DMAS estimates that between 14% and 20% of members will lose coverage during the "PHE unwinding" period, although an additional 4% are expected to lose and regain their coverage within one to six months after the closure of the unwinding period. Once the PHE ends and the redeterminations are completed, the number of Medicaid members eligible for dental benefits will decrease accordingly.

As of this writing, the PHE officially will continue at least through January 11, 2022. The Biden administration has indicated it will provide states with a 60-day notice prior to the end of the PHE.

Figure 8
Medicaid/FAMIS Enrollment by Category of Eligibility



Note: Adults include Medicaid Expansion
Source: DMAS, Board of Medical Assistance Services Presentation, June 2022

Impact of COVID-19 Pandemic on Dental Practices

In addition to the suspension of Medicaid eligibility redeterminations due to the PHE, COVID-19 impacted dental practices. In the early stages of the pandemic, dental offices were forced to close except for certain emergency procedures. As dental practices slowly started to re-open for regular non-emergency appointments, they had to re-schedule a large backlog of patients and address pandemic-related staffing issues. As a result, appointments for all dental patients (including Medicaid/FAMIS members) were being scheduled several months out. At some practices, this backlog is still impacting availability of appointments.

Medicaid/FAMIS Members' Utilization of Dental Services

Utilization of dental services by Medicaid/FAMIS members is another important indicator of access to care. Generally, measuring Medicaid/FAMIS dental service utilization is done by analyzing three dental service data elements: (i) members receiving any dental service; (ii) members receiving preventive dental services; and (iii) members receiving dental treatment services. For purposes of this report, data regarding those members receiving "any dental service" are included in three categories of enrollment: children (under 21); pregnant members; and adults. Statewide and regional utilization data are presented for these groups; data are also reported by race/ethnicity for children.

[1]Versaci, Mary Beth, (2022, May 25) American Dental Association, *JADA article highlights key elements from Oral Health in America report, finding poor oral health limits participation in workforce, increases health care costs,* https://www.ada.org/publications/ada-news/2022/may/jada-article-highlights-key-elements-from-oral-health-in-america-report.

Children's Utilization of Any Dental Service

As seen in Figure 9, children's utilization of any dental service has gradually increased from 53.0% in 2012 to 57.7% in 2018. The COVID-19 pandemic contributed to the utilization decline to 50.8% in 2020 and 48.6% in 2022.

From a regional perspective, utilization of services generally followed the same gradual increases between 2012 and 2018. The Northern Virginia region had the highest level of utilization in each year. The lowest utilization levels were seen in Southwest Virginia and Eastern Virginia; however, the rates in these regions were not significantly lower than the statewide averages.

Figure 10 illustrates the utilization of any dental service by race/ethnicity of Medicaid/FAMIS children under age 21. As noted above, utilization levels in 2020 and 2022 were lower than prior years largely due to the pandemic.

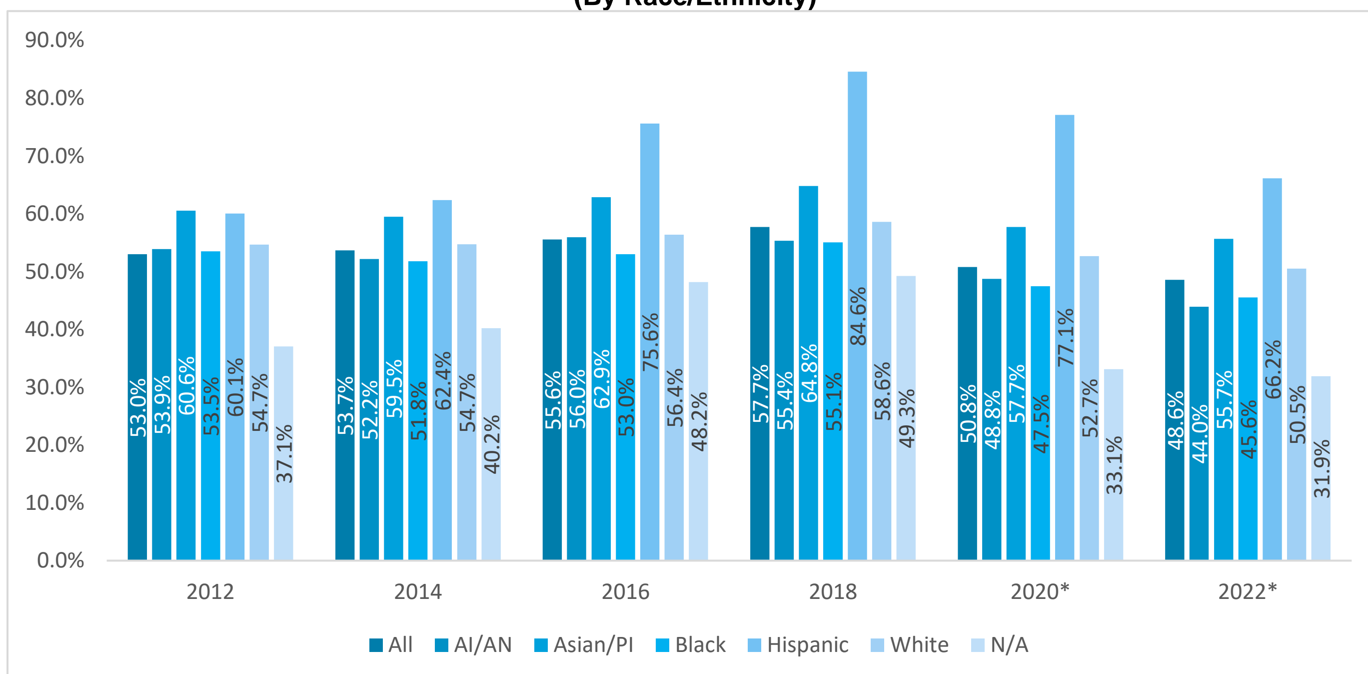
Hispanic children have the highest utilization levels in each year from 2012-2020, followed by Asian/Pacific Islanders. Black children have the lowest utilization percentage of any identifiable race/ethnicity category.

Children's utilization of dental services needs to improve across all regions of the Commonwealth and among all children; however, these data underscore the need for even greater and more focused outreach to Black children and their families. Additionally, steps such as enhanced outreach, oral health education and provider recruitment efforts could improve utilization rates, particularly in Southwest and Eastern Virginia.

Figure 9
Utilization of Any Dental Service: Medicaid/FAMIS Children (<21)
(Statewide and by Region)

Source: DBA: *Smiles For Children* utilization data
Note: Years represent State Fiscal Years. *2020 and 2022 utilization of dental services were impacted by COVID-19 pandemic. Regions: NWVA-Northwest VA; NVA-Northern Virginia; SWVA-Southwest VA; CVA-Central Virginia; EVA-Eastern Virginia

Figure 10
Utilization of Any Dental Service: Medicaid/FAMIS Children (<21)
(By Race/Ethnicity)



Source: DBA: *Smiles For Children* utilization data
Note: Years represent State Fiscal Years. *2020 and 2022 utilization of dental services were impacted by COVID-19 pandemic. AI/AN-American Indian/Alaskan Native; Asian/PI-Asian/Pacific Islander; N/A- Not Applicable (no race information on eligibility file)

Utilization of "Any Dental Service" by Pregnant Members

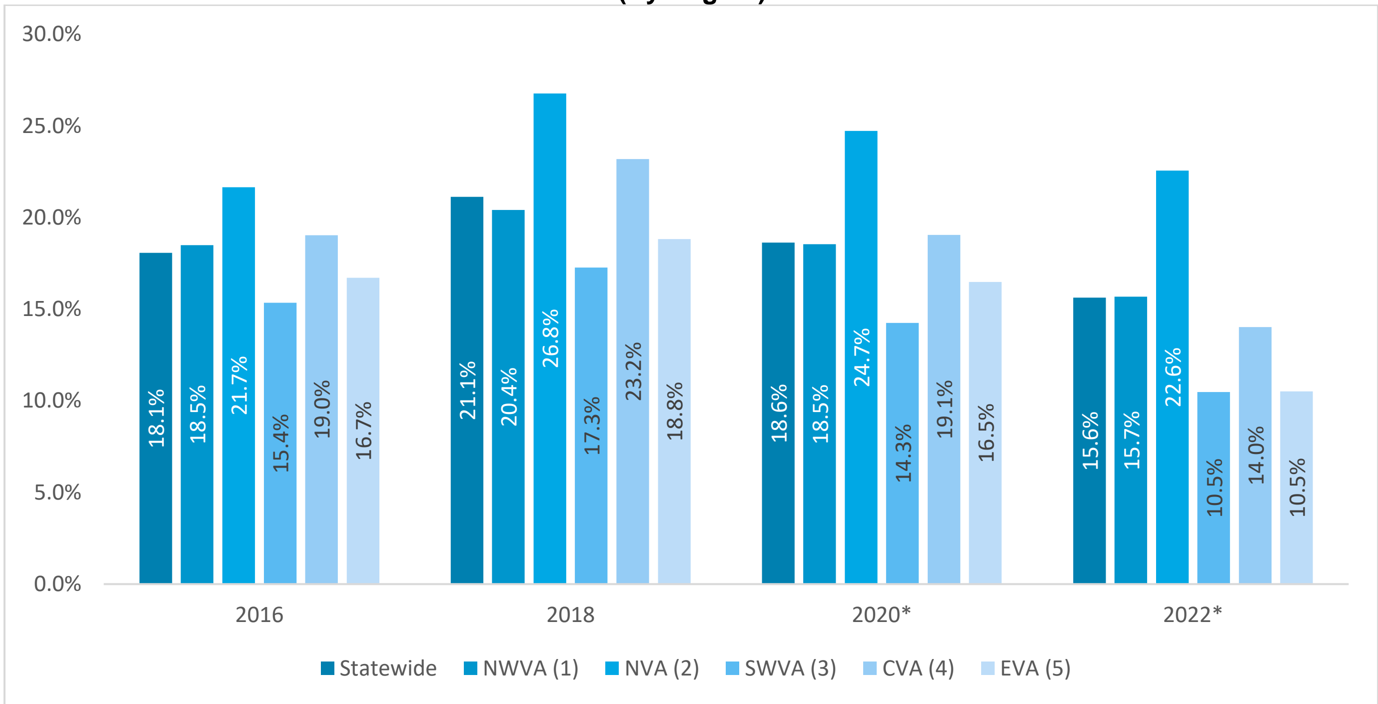
Pregnant members' utilization of any dental service is shown in Figure 11 and denotes utilization both statewide and by region. Overall, utilization for pregnant members is lower than that for children with percentages for both statewide and the regions ranging from the mid-upper teens to the low-mid 20s. Since dental benefits for pregnant members did not begin until March 2015, the program is still relatively new; FY2016 is the first fiscal year with 12 months of data. (Postpartum Medicaid coverage, including dental services, for pregnant members was extended to 12 months effective July 22, 2022.)

The highest level of utilization occurred in Northern Virginia; utilization in Southwest Virginia was the lowest. The increase in utilization seen from 2016 to 2018 (statewide and all regions) indicates a growing awareness of the program. Unfortunately, the pandemic clearly resulted in lower utilization in 2020 and 2022.

Currently, utilization of dental services by pregnant members is not available by race/ethnicity. DBA is working to add this level of analysis as soon as possible. Given the higher pre-term birth rates of Black mothers in Virginia, this is an important functionality and will help DMAS ensure mothers of all races and ethnicities are accessing dental care.

Ongoing outreach and education for both pregnant members and dental providers from DMAS, DMAS' dental benefits administrator, the MCOs, and stakeholder/ advocacy groups is essential to improving access to dental services.

Figure 11
Utilization of Any Dental Service: Pregnant Members (>21)
(By Region)



Source: DentaQuest: *Smiles For Children* utilization data. (FY2016 was the first year of comprehensive dental benefits for pregnant members.)
Note: Years represent State Fiscal Years. *2020 and 2022 utilization of dental services were impacted by COVID-19 pandemic. Regions: NWVA-Northwest VA; NVA-Northern Virginia; SWVA-Southwest VA; CVA-Central Virginia; EVA-Eastern Virginia. A member does not need to be enrolled in pregnancy coverage in order to receive pregnancy dental benefits while enrolled, however we were only able to identify dental utilization for pregnant members who are in the pregnant member enrollment group.

Adults' Utilization of "Any Dental Service"

As previously noted, comprehensive dental benefits for Medicaid adults did not begin until July 1, 2021. Prior to that time, adults were eligible for limited benefits, primarily extractions. The limited nature of the adult dental benefits in FY2012 through FY2020 is evident in Figure 12, which shows a very small percentage of adults received any dental service during these years. Statewide, 9.7% of adults received any service in 2012; that percentage grew to 12.5% in 2020. Regional utilization percentages were fairly consistent; however, unlike utilization by children and pregnant members, Northern Virginia had the lowest percentage for adults from 2012 to 2016. By 2022, Northern Virginia had the highest level of utilization at 24.5%.

Figure 12 reflects an increase in adult utilization, both statewide and regionally, after the comprehensive dental benefit was added in FY2022. Based on DBA data, the statewide utilization rate of 16.8% equates to approximately 165,000 Medicaid adults receiving dental services in the first year of the program.

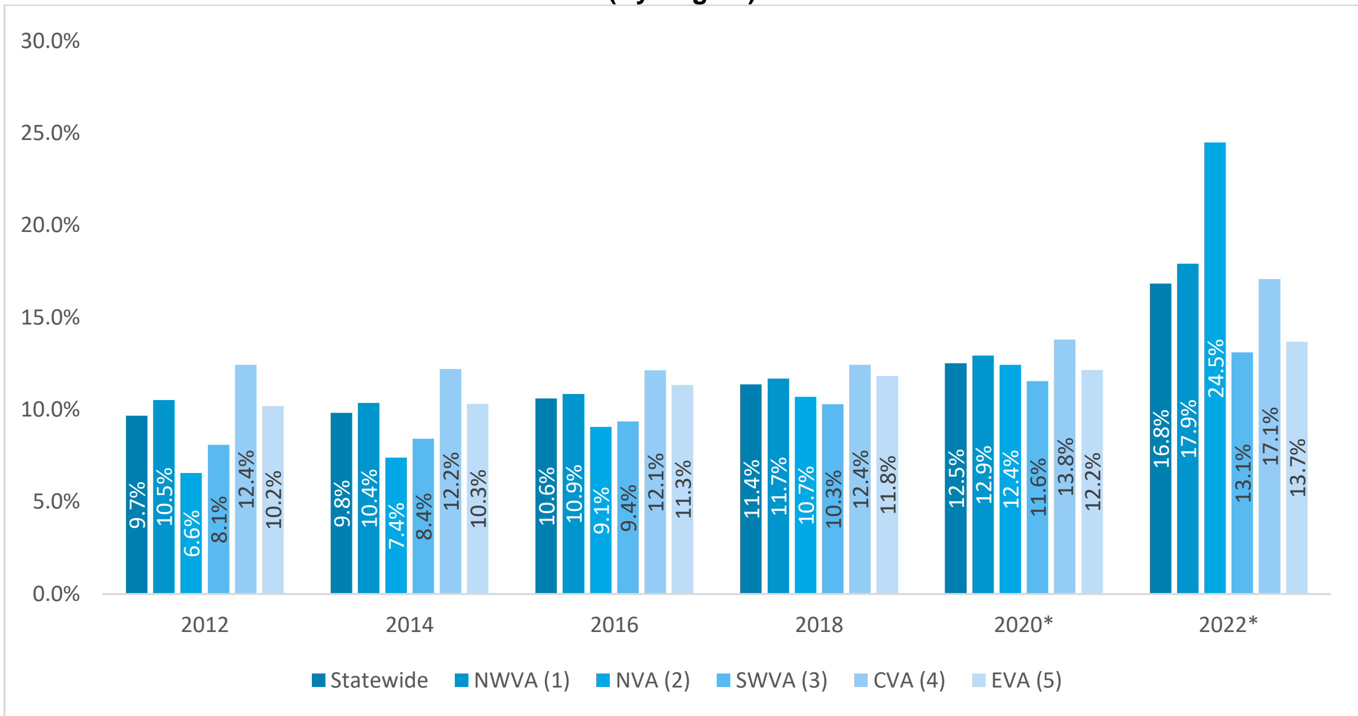
Figure 13 illustrates the type of services members are receiving. Restorations (e.g., fillings) continue to be the most common service, followed by extractions and then prophy treatments (i.e., cleanings). Over time, the expectation is there will be fewer extractions and an increase in prophies and restorations as adults have greater access to care and improvements in their oral health.

Adult vs. Children's Utilization of Dental Services

The significant difference in utilization between children and adults mirrors data from other states that provide comprehensive dental benefits for adults. ADA-HPI analysis indicates the average utilization rate in these states for adults is 28.4%, well below the average utilization rate for Medicaid/CHIP children. The ADA-HPI also reports adult utilization generally ramps up over a 2 to 3 year period after implementation before it begins to level off.

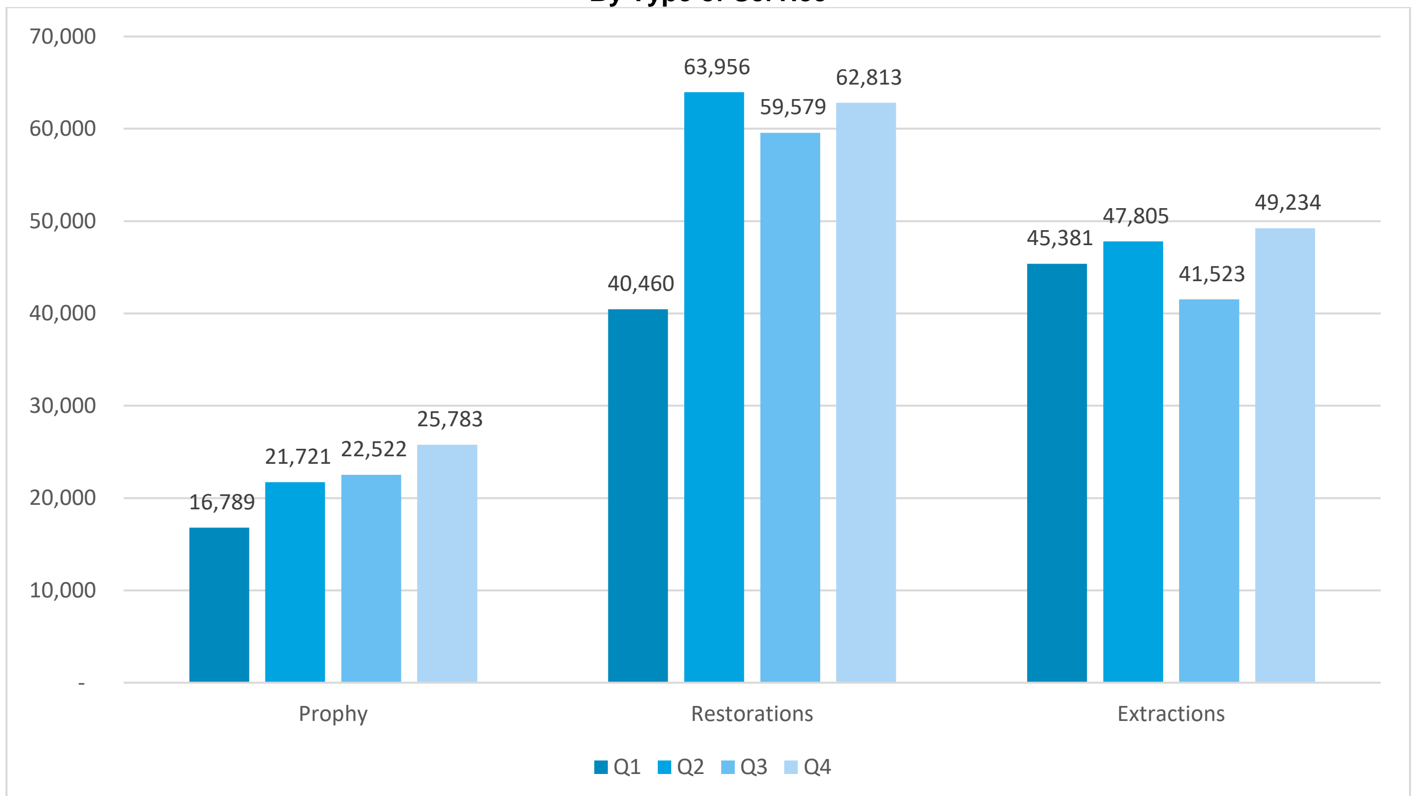
Based on stakeholder input, the 16.8% statewide utilization rate for adults in 2022 suggests adults are facing greater difficulty accessing care. This likely is due to several factors including the newness of the comprehensive adult dental benefits, lower reimbursement prior to July 2022, and fewer dentists treating adults.

Figure 12
Utilization of Any Dental Service: Adults
(By Region)



Source: DBA: *Smiles For Children* utilization data. (FY2022 was the first year of comprehensive dental benefits for adults.)
Note: Years represent State Fiscal Years. *2020 and 2022 utilization of dental services were impacted by COVID-19 pandemic. Regions: NWVA-Northwest VA; NVA-Northern Virginia; SWVA-Southwest VA; CVA-Central Virginia; EVA-Eastern Virginia

Figure 13
FY2022 Utilization of Dental Service: Adults
By Type of Service



Source: DentaQuest: *Smiles For Children* adult utilization data for FY2022.

VIRGINIA'S MEDICAID PROGRAM DMAS

One reason some dentists tend not to treat adults is that they can present with a different level of need and, while it is still dental care, these differences can pose challenges for the provider. As a result, providers willing to treat patients who are twenty years old and younger may not be willing to treat adults. Issues related to the COVID-19 pandemic also affected utilization rates, including offices being overwhelmed as more people became comfortable utilizing services again, office being short-staffed, and office-cleaning protocols causing longer appointment times.

Another issue in play are concerns voiced by some dentists about certain administrative and operational aspects of the adult dental program. These relate primarily to broken appointments and certain benefit limitations. These are addressed later in the report.

The Most Frequently Cited Access Issue Mentioned by Stakeholder Groups Was That There Are Too Few Dentists Treating Medicaid/FAMIS Members

Several of the stakeholder groups who provided input for this study mentioned there are not enough dentists participating in the program who are actively treating Medicaid/FAMIS patients. These stakeholders include several advocacy groups, individual dentists who treat Medicaid/FAMIS patients, and the Virginia Commonwealth University (VCU) School of Dentistry. VCU specifically noted that a shortage of dentists in the community treating Medicaid/FAMIS patients has resulted in a significant increase in the number of patients, primarily adults, coming to the dental school for treatment. VCU has indicated a willingness to see as many patients as it can but notes the current patient demand is resulting in very long wait times for appointments and is straining available resources.

While the concern of too few dentists applies generally to Medicaid/FAMIS members, stakeholder feedback indicates it is more pronounced among certain segments of the Medicaid population including persons with disabilities, nursing facility residents, and persons living in rural areas. Providers may be hesitant to treat Medicaid members with these special needs and conditions. There are other Medicaid/FAMIS members who may be facing more pronounced access issues, but the aforementioned patient subgroups are consistently mentioned here in Virginia, in the experiences of other state Medicaid programs, and throughout the findings of numerous studies cited in literature such as the Delta Dental Foundation and University of Pennsylvania.

Persons with Disabilities

Advocacy groups and providers serving persons with disabilities have long cited the additional burden their clients face in accessing dental care. The Surgeon General's Report on Oral Health in America released in 2000 highlighted the barriers these patients face in obtaining dental care and the resulting poor oral health outcomes. The 2021 follow-up report issued by the National Institute for Dental and Craniofacial Research (NIDCR) noted barriers to care for such populations still exist and greater efforts are needed to combat these disparities.

A 2022 National Council on Disability Report noted "there is a lack of dental providers who serve Medicaid patients, due not only to the lack of training, but likely compounded by low Medicaid reimbursement rates." The report also identified the "difficulties in accessing operating rooms (ORs) in hospitals for oral health procedures and providing specialized care: Adults with serious I/DDs may require general anesthesia to receive preventive oral health care because they cannot tolerate dental care otherwise. Thus, they must receive oral health care in a hospital setting or in outpatient dental surgery settings."

Nursing Facility Residents

Several nursing facility representatives indicated their residents also face additional barriers to oral health care due to their frail health, the difficulties they encounter in securing transportation to the dentist, and the limited number of dentists who are equipped and able to treat these patients. Moreover, transporting residents to a dental office often requires a facility staff member accompany the patient to the dentist which exacerbates existing staffing shortages.

Representatives of the nursing facility industry indicated on-site dental clinics that can provide a broad range of dental services holds the most promise for improving the oral health of their residents. In addition to on-site dental clinics at multiple facilities, a "regional" approach was also mentioned, wherein a "hub" clinic could be established at one facility in a given region and could offer dental services not only to its residents, but also residents of other nearby facilities. While the "hub"/regional model still may encounter challenges getting residents from other facilities to the on-site dental clinic, they are not expected

to be at the same level of concern as getting residents to private offices.

Lucy Corr Retirement Center in Chesterfield County has operated an on-site dental clinic for several years. The clinic has been successful in increasing access to dental care for its residents.

While there are a number of administrative and logistical details that would need to be resolved in establishing on-site dental clinics at nursing facilities, this alternative approach of providing care to this vulnerable population is worthy of further study.

Residents of Rural Areas

Rural areas in Virginia as well as other states have long struggled with greater challenges in provider availability, including dental providers. As illustrated in Figures 4 and 5, areas such as Southwest Virginia typically have fewer available providers and resources, causing residents to travel greater distances to access care. Regional socio-economic, geographic, and demographic conditions often further complicate access to care.

Dentists Cite Inadequate Fees As a Major Disincentive to Participating in the Smiles For Children Program & Treating Members

While the Department anticipates a favorable impact of the recent rate increase, as previously noted, prior to the 2022 Session of the General Assembly, Virginia Medicaid/FAMIS dental reimbursement fees had not been increased since 2005. The American Dental Association (ADA) recently reported that inflation has surged another 1.9% in June 2022 and 35% of dentists surveyed for the report said inflation and increasing costs were among their most significant concerns. (This inflationary increase in the cost of dental services took place during a period of historic increases in inflation across many products and services.) Dentists noted that staffing shortages related to the COVID-19 pandemic was the most significant challenge.

Prior to the July 2022 rate increases, the lack of any fee increases since 2005 is evident in a 2021 Adult Dental Provider Survey of dentists participating in the ***Smiles For Children*** program. The survey, conducted by the current DBA, DBA, found that inadequate reimbursement was the primary concern cited by dentists that would prevent them from treating Medicaid adults. Of the concerns noted by dentists in the survey, the overwhelming majority were related to low fees. Moreover, for the past several years, inadequate fees have been the primary reason noted by dentists in other settings across the state for not participating in the program.

Feedback from the stakeholder engagement process emphasized an ongoing need to keep rates in line with inflation and private insurance reimbursement to avoid dentists leaving the program. They indicated more frequent rate analyses are needed to inform program decision makers and legislators about the adequacy of rates and any necessary rate adjustments.

Potential Future Benefit and Reimbursement Modifications to Improve Access to Care

As noted at the beginning of this report, “access to care” is a function of more than provider availability. It is also necessary to have a benefit design that not only provides coverage for necessary services but also encourages providers’ active participation in the program.

All Medicaid/FAMIS members receive comprehensive dental benefits. While there is no need for any major changes in the benefits, the feedback received from various stakeholders did identify a few modifications that would enhance Medicaid/FAMIS members’ access to care, address some dentists’ concerns about the program, and/or provide additional incentive for providers to treat more patients. The following sections summarize the suggestions offered by stakeholders.

Behavior Management Fee

For pediatric patients with I/DD diagnoses and those with behavior management issues, increased staff support is often needed to facilitate their care. For children, dentists can bill an adjunctive code (D9920) for “patient behavior management” up to four times per patient per year (within certain guidelines) to increase the patient’s comfort level and ability to receive dental services. This fee compensates the dental office for the additional resources and time required to treat these patients and is in addition to other fees billed for services rendered.

Earlier in this report it was noted that several stakeholders mentioned the additional challenges faced by persons with disabilities in accessing dental care. Persons with I/DD diagnoses often require more assistance and attention from the dentist and other staff so they can receive dental treatment, including basic services. Persons with certain behavioral health diagnoses also may need more individualized attention to increase their comfort level.

For adult patients with certain disabilities, dentists can bill for "patient behavior management" (D9920) up to five times per year per adult. Stakeholders noted that persons with disabilities often can only tolerate limited time in the dental chair and therefore require more visits to complete a treatment plan; this is a more pronounced issue with adult members. Removing the limitation on the number of times a dentist can bill for D9920 and allowing the use of this code for each adult patient visit could stimulate greater provider willingness to treat these patients and help ensure they receive the full regiment of needed care. The modification being suggested here would not be for the entire adult population, rather for patients where it is medically necessary to complete the treatment.

Crown Procedures for Patients Who Received Root Canal Therapy Prior to Becoming a Medicaid Beneficiary

A recurring concern offered by a number of dentists and the Ad Hoc Committee on Dental Fees relates to a current restriction in the ***Smiles For Children*** program that disallows payment for placement of a crown if the patient received root canal therapy (RCT) prior to becoming eligible for Medicaid. These dentists noted that after root canal treatment, teeth may become brittle and the crown of the tooth subject to fracture. Covering these teeth with a crown preserves the integrity of the tooth and increases service longevity.

Allowing payment in these circumstances will provide better quality care for patients, reduce the amount of return visits, and free up appointment times for dentists to treat other patients.

Patients Needing Sedation or General Anesthesia

A number of dental patients need sedation or general anesthesia to complete their necessary treatment. These patients include persons with disabilities and those with other conditions that preclude them from accessing care in more traditional settings. Depending on the patient's treatment needs and other health characteristics, patients may require one of three levels of sedation: minimal sedation, moderate sedation, or deep sedation/general anesthesia.

If an individual has to undergo anesthesia/sedation for dental care, a detailed battery of questions and clinical work-up is required in order to risk-stratify the patient. This information allows the dental team, including the dental anesthesiologists, to gather pertinent medical information, seek necessary consultation with medical providers, request pre-anesthesia testing as indicated, and review any previous untoward sedation occurrences.

In recognition of the aforementioned pre-operative process, the ADA's "Guidelines for the Use of Sedation and General Anesthesia by Dentists" require a pre-operative evaluation of the patient for all levels of sedation.

Currently, the ***Smiles For Children*** program does not reimburse dentists for these pre-treatment patient evaluations. The addition of CDT Code D9219 (evaluation for deep sedation or general anesthesia) to the list of reimbursable services would enable dentists to bill for these evaluations. Dentists who participated in the stakeholder engagement process indicated the inclusion of this code would encourage more dentists to treat this subgroup of Medicaid/FAMIS patients who need this additional level of care.

Access to Hospital Operating Rooms

A related issue regarding the need to treat some patients with sedation or general anesthesia is the availability of hospital operating room time to perform the procedures. Concerns about limited access to operating rooms for dental procedures have been voiced by the dental community and advocacy groups for several years. A 2021 report by the American Academy of Pediatric Dentistry (AAPD) stated that *"denial of access to hospital operating rooms for pediatric dental care is a growing problem in the U.S., with the majority of states having some manifestation of this problem. Financial pressures have forced hospitals to prioritize surgical services based on profitability and necessity. Medical surgery procedures are better reimbursed than dental and displace dental cases from scheduling in many hospitals."*

Prompted by advocacy from the dental community, the Centers for Medicare and Medicaid Services (CMS) has proposed a rule that would increase the facility fee for dental surgeries performed in hospital operating rooms, thereby increasing access to dental rehabilitation surgery for patients who need extensive dental procedures performed in this setting. Specifically, CMS is proposing an increase in the CPT code (41899) which is frequently used by hospitals to bill the facility fee for dental operating room cases. The proposed increase is from the current rate of $203.64 to $1,958.92, nearly a tenfold increase. If adopted, this rule change, along with Virginia's 30% increase in dental professional fees, should increase the availability of hospital operating rooms for Medicaid/FAMIS dental patients.

Assuming this proposed rule becomes final, DMAS' capitation rates paid to the MCOs may need to be adjusted to account for the increased hospital facility fees being billed for dental surgeries. DMAS will continue to monitor this development.

Fluoride Varnish Provided by Medical Providers

DMAS reimburses non-dental practitioners, such as medical providers, for applying fluoride varnish on children who are eligible for this service. Fluoride varnish is a concentrated form of fluoride that is applied to the patient's teeth to help prevent tooth decay or stop it from getting worse.

Currently, non-dental providers are reimbursed for applying fluoride varnish on children through age 3. Extending the age limitation to children through age 5 would align the ***Smiles For Children*** program with the recommendations of the U.S. Preventive Services Taskforce, the American Academy of Pediatrics, and the American Academy of Pediatric Dentistry. Doing so would improve access to this highly effective preventive service for more children.

Providing Reimbursement for Dental Providers Who Treat Pediatric Patients Outside of the Dental Office

The Code of Dental Terminology (CDT) includes Code 9410 (house/extended care facility call). This adjunctive code provides an additional reimbursement for services provided outside of the dental office and is in addition to the fee for the actual dental service that is provided. As further described in the CDT, Code D9410 may be billed for treating patients at locations such as nursing homes, long-term care facilities, hospice sites, institutions, etc.

The ***Smiles For Children*** program covers this code for adults who reside in the types of facilities identified above. Currently, it is not covered for children (under 21 years of age), so it cannot be billed for oral health services provided to children at schools, Head-Start programs, etc. Some stakeholders noted that making this code reimbursable for care provided to children outside of the dental office would encourage more dental providers to treat pediatric members in other settings where children congregate, resulting in greater utilization of services and better oral health for these patients.

It is not clear whether this code is intended to extend to locations or programmatic sites that are not long-term care types of residences. The meaning of "etc." in the detailed code definition is unclear. Some state Medicaid programs have considered this to mean "other types of extended care facilities" (e.g., New Jersey Administrative Code 10:56-2.5). On the other hand, North Dakota Medicaid allows payment for this code for dental providers delivering care to children at different out-of-office sites (e.g., school-based programs and Head Start programs).

Given the uncertainty of the intended application of this code, DMAS will conduct further inquiry into this issue and assess the viability of expanding the use of this code to children services.

Other Potential Actions to Improve Access to Dental Care

Stakeholders Cite Broken Appointments and Non-Emergency Medical Transportation As Continuing Problems

Broken appointments have long been a major concern of dentists participating in Medicaid dental programs. "No-shows" create gaps in dental practice schedules and result in lost revenue. A higher rate of "no-shows" among Medicaid members than private insurance patients disincentivizes dentists from participating in Medicaid dental programs. Among dentists responding to DBA's 2021 provider satisfaction survey, 84% said broken dental appointments are a moderate to major problem.

Broken appointments can result for many reasons, including a patient's inability to take leave from work, child-care issues, and personal transportation problems. Stakeholders who provided input into this study also mentioned Medicaid non-emergency medical transportation (NEMT) as a continuing problem and frustrating for both patients and providers. Medicaid programs across the nation have struggled with this issue for years, not just with respect to dental care, but other services as well.

In Virginia, transportation brokers are used to manage NEMT services. DMAS contracts with a broker for fee-for-service members. DMAS' contracted managed care organizations (MCOs) also use a broker who manages NEMT services for their respective members.

Continued efforts by DMAS, DBA, the dental community, the VDA, advocacy groups, the MCOs, and the NEMT brokers will be needed to address the challenges posed by broken appointments and Medicaid transportation.

Actions and Recommendations

This section identifies two categories of responses to the findings of this study to support provider engagement and participation. The first is a list of actions DMAS intends to pursue on its own within current funding and authority. The second category lists several potential recommendations the Commonwealth may wish to consider.

DMAS Actions

1. DMAS, in conjunction with stakeholders will develop and implement a statewide recruitment campaign to increase the number of actively participating dentists treating Medicaid/FAMIS members. DMAS will work with its Dental Advisory Committee, the Old Dominion Dental Society, the Virginia Dental Association, the Virginia Dental Hygienists Association, and other advocacy groups in planning and implementing the campaign.

   The campaign will incorporate specific strategies to address the most underserved areas and populations, provider hesitation, as well as those dental specialties with the greatest need, for more actively participating dentists.

2. DMAS will work with its contracted Dental Benefits Administrator to conduct a thorough review of the status of the dental network every two years. The review will focus on the number of actively participating dentists treating Medicaid/FAMIS patients statewide by region, and type of dental specialty. For each review, DMAS will make the report findings available online by October 1 beginning in 2024 and on a biennial basis thereafter.

3. DMAS will analyze dental fees every three years in order to calculate what rate increases and additional funding is needed to at least maintain the current percentage of Medicaid/FAMIS rates as compared with commercial insurance fees (approximately 82%-83%). A report of DMAS' findings will be made available online and provided to the Department of Planning and Budget, the House Appropriations Committee, and the Senate Finance and Appropriations Committee. For each year the analysis is conducted, DMAS will submit the report and make it available online by July 1, beginning in 2025.

4. DMAS will begin tracking and reporting the number of dental providers who are actively participating (i.e., treating Medicaid/FAMIS patients). This will be in addition to the number of overall providers contracted with the program.

   DMAS will utilize the same categories of "number of patients treated" as developed by the American Dental Association's Health Policy Institute (i.e., no patients, 1-9 patients, 10-100 patients, and more than 100 patients).

   All relevant provisions of the DBA contract that reference participating or contracted providers will be amended to track the same information regarding the number of providers actively participating in the program (i.e., treating Medicaid/FAMIS patients).

5. DMAS will work with the Department's Dental Advisory Committee, the Virginia Health Care Association, the Virginia Dental Association, the Old Dominion Dental Society, and the Virginia Dental Hygienists Association to determine the feasibility of implementing an on-site dental clinic pilot program at one or more nursing facilities.

6. DMAS will work with the Department's Dental Advisory Committee, the dental provider community, and DBA to identify specific actions that can be taken to reduce broken appointments. DMAS also will work with its non-emergency medical transportation (NEMT) broker, the MCOs and other stakeholders to find ways for improving transportation to dental appointments. As part of this work, DMAS will reach out to other state Medicaid programs to learn of any successful strategies to address both NEMT issues and broken appointments.

Potential DMAS Actions

1. The Commonwealth may wish to consider removing the current limitation on the number of times (5 per patient per year) a dentist can bill for CDT Code D9920 when treating adults with disabilities.

2. The Commonwealth may wish to consider authorizing payment for crowns for those patients

who received root canal therapy prior to becoming a Medicaid beneficiary.

3. The Commonwealth may wish to consider authorizing reimbursement for pre-treatment evaluations (CDT Code D9219) performed by dentists treating patients requiring deep sedation or general anesthesia. Inclusion of this code would encourage more dentists to treat this subgroup of Medicaid/FAMIS patients who need this additional level of care.

4. The Commonwealth may wish to consider extending the age limitation for children receiving fluoride varnish from non-dental providers from "through age 3" to "through age 5." This would align the ***Smiles For Children*** program with the recommendations of the U.S. Preventive Services Taskforce, the American Academy of Pediatrics, and the American Academy of Pediatric Dentistry.

   - The Commonwealth may wish to consider expanding certain preventive services for children to reduce caries development and improve oral health. These include increasing the allowable number of fluoride varnish applications from twice per year to four times per year, removing the once-per-lifetime cap on sealants and allow reimbursement for sealants once every three years, and increasing the number of allowable panorex radiographs from once every five years to once every three years.

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- Kristen Gilliam (DentaQuest, Senior Client Partner)
- Justin Gist (DMAS Dental Program Manager)
- Patrick Finnerty

Appendix A

Counties and Cities in Each Region of Virginia

Region 1 (Northwest Virginia)

Albemarle, VA, Augusta, VA, Bath, VA, Caroline, VA, Clarke, VA, Culpeper, VA, Fauquier, VA, Fluvanna, VA, Frederick, VA, Greene, VA, Highland, VA, King George, VA, Louisa, VA, Madison, VA, Nelson, VA, Orange, VA, Page, VA, Rappahannock, VA, Rockbridge, VA, Rockingham, VA, Shenandoah, VA, Spotsylvania, VA, Stafford, VA, Warren, VA, Buena Vista City, VA, Charlottesville City, VA, Fredericksburg City, VA, Harrisonburg City, VA, Lexington City, VA, Staunton City, VA, Waynesboro City, VA, Winchester City, VA

Region 2 (Northern Virginia)

Arlington, VA, Fairfax, VA, Loudoun, VA, Prince William, VA, Alexandria City, VA, Fairfax City, VA, Falls Church City, VA, Manassas City, VA, Manassas Park City, VA

Region 3 (Southwest Virginia)

Alleghany, VA, Amherst, VA, Appomattox, VA, Bedford, VA, Bland, VA, Botetourt, VA, Buchanan, VA, Campbell, VA, Carroll, VA, Craig, VA, Dickenson, VA, Floyd, VA, Franklin, VA, Giles, VA, Grayson, VA, Henry, VA, Lee, VA, Montgomery, VA, Patrick, VA, Pittsylvania, VA, Pulaski, VA, Roanoke, VA, Russell, VA, Scott, VA, Smyth, VA, Tazewell, VA, Washington, VA, Wise, VA, Wythe, VA, Bedford City, VA, Bristol City, VA, Clifton Forge City, VA, Covington City, VA, Danville City, VA, Galax City, VA, Lynchburg City, VA, Martinsville City, VA, Norton City, VA, Radford, VA, Roanoke City, VA, Salem City, VA

Region 4 (Central Virginia)

Amelia, VA, Brunswick, VA, Buckingham, VA, Charles City, VA, Charlotte, VA, Chesterfield, VA, Cumberland, VA, Dinwiddie, VA, Goochland, VA, Greensville, VA, Halifax, VA, Hanover, VA, Henrico, VA, Lunenburg, VA, Mecklenburg, VA, New Kent, VA, Nottoway, VA, Powhatan, VA, Prince Edward, VA, Prince George, VA, Surry, VA, Sussex, VA, Colonial Heights Cit, VA, Emporia City, VA, Hopewell City, VA, Petersburg City, VA, Richmond City, VA, South Boston City, VA

Region 5 (Eastern Virginia)

Accomack, VA, Essex, VA, Gloucester, VA, Isle of Wight, VA, James City, VA, King and Queen, VA, King William, VA, Lancaster, VA, Mathews, VA, Middlesex, VA, Northampton, VA, Northumberland, VA, Richmond, VA, Southampton, VA, Westmoreland, VA, York, VA, Chesapeake City, VA, Franklin City, VA, Hampton City, VA, Newport News City, VA, Norfolk City, VA, Poquoson City, VA, Portsmouth City, VA, Suffolk City, VA, Virginia Beach City, VA, Williamsburg City, VA