THE 2017 EDITION

CENTRIPETAL
Centered on Behavioral Health

TRENDS IN BEHAVIORAL HEALTH:

A Reference Guide on the U.S. Behavioral Health Financing & Delivery System

Brought to you by

Otsuka Lundbeck

September 2017 00US17EUB0001

FOREWORD

Over 43 million people in the United States suffer from a mental illness and more than 20 million Americans have an addictive disorder.[1,2]

The incidence of co-occurring mental illnesses and addictive disorders is high, requiring specialized treatment approaches. In 2014, behavioral health treatment expenditures totaled $220 billion.[3] While treatment of these disorders is less than eight percent of total health care spending, the impact of these illnesses is far greater.[3] Individuals with a behavioral disorder use at least two times more total health care resources than individuals without a behavioral disorder.[4] And, behavioral health disorders also have a large socioeconomic and human impact on the nation as a whole. Improving the behavioral health delivery systems, in terms of care coordination, consumer access, and quality, is a critical component in improving the overall effectiveness and efficiency of the U.S. health care system.

To contribute to the work of the thousands of dedicated professionals in the health care field focused on issues related to behavioral health disorders, Otsuka America Pharmaceutical, Inc. (OAPI) and Lundbeck are pleased to share with you this first annual reference guide, *Trends in Behavioral Health: A Reference Guide on the U.S. Behavioral Health Financing & Delivery System*. OAPI and Lundbeck are engaged in a collaborative long-term global alliance agreement based on a shared heritage of research and development in neuroscience. We believe this collaboration will lead to new products that will have a positive impact on a broad range of behavioral health conditions improving the lives of millions of people. Lundbeck and OAPI always want to be at the cutting edge of the health care field. We empower our people to push the boundaries of creativity and convention.

Our goal with this reference guide is to make a positive contribution to the national conversation among key stakeholders, including commercial and government payers, integrated delivery networks, and providers, about the disproportionate effect of behavioral health disorders on the U.S. health care system, and the trends shaping the field. The guide includes an update on key national policies, a state-by-state landscape analysis, key metrics on behavioral health service delivery capacity and quality metrics, and a national survey of health plans on population health management approaches specific to individuals with complex support needs with behavioral disorders.

In this guide, you will discover that it is a vastly different landscape than prior to the implementation of the Affordable Care Act[3], shaping the care for individuals with behavioral disorders. And, each year, our goal is provide an update on the complex equation that encompasses health care coverage and financing, care management options, and the availability and quality of services being delivered.

We hope you find the information in this reference guide valuable in advancing your good work, and we welcome your comments.

Sincerely,

Sean Phillips, Pharm. D. | Otsuka, Vice President Managed Markets

Brian McCarthy | Lundbeck, Vice President Managed Markets

TABLE OF CONTENTS

I. Executive Summary **6-7**

II. National Behavioral Health System Landscape **8-15**

- Executive Summary 8
- U.S. Health Care Coverage Trends 8-9
- Federal Behavioral Health Policy Initiatives 10-12
- Veterans and Behavioral Health Care 12-15

III. State Behavioral Health Financing and Service Delivery Systems **16-23**

- Executive Summary 16
- State Behavioral Health Systems Typology Chart and Medicaid Behavioral Health Financing Arrangements 16-17
- State Behavioral Health Care Coverage and Reference Chart 19
- State Medicaid Financing Systems for the SMI Population 19
- State Innovation Initiatives and Reference Chart 20-23

IV. Health Plan Population Health Management **24-29**

- Executive Summary 24
- Health Plan Current and Future Use of Analytics in Identification and Early Intervention of High Risk Consumers 24
- Health Plan Current and Future Use of Innovations in Improving Consumer Access to Behavioral Health Treatment Strategies 25-26
- Health Plan Current and Future Use of Behavioral Health Consumer Engagement Strategies 26
- Health Plan Current and Future Use of Models to Improve Coordination of Care for Consumers With Behavioral Health Conditions 27
- Health Plan Current and Future Use of Behavioral Health Strategies For Ensuring Quality of Care 28
- Health Plan Current and Future Use of Behavioral Health Provider Partnership Models 29

V. Consumer Access and Delivery of Care **30-37**

- Executive Summary 30
- Consumer Access to Behavioral Health Care 30-33
- Behavioral Heath Care Quality 34-37
- The Centers for Medicare and Medicaid Services Quality Measures 37

VI. Additional Resources **38**

VII. Sources **39-46**

EXECUTIVE SUMMARY

This 2017 first edition of *Trends in Behavioral Health: A Reference Guide on the U.S. Behavioral Health Financing & Delivery System* (The Guide) provides information and insights into the multi-layered United States behavioral health system. The Guide includes a snapshot of current statistics, current issues, and emerging trends in order to inform the discussions, debates and decision-making of policy-makers, payers, providers, advocates and consumers in today's dynamic health care environment. It begins with the national policy context that is shaping the U.S. health and human services market – and by extension the behavioral health market. The Guide then focuses on the unique state behavioral health delivery systems that were created by a combination of historical practices, federal and state policy, and market factors over the past years. It also examines the practices of health plans that now manage the health care and behavioral health care for over 75% of the U.S. population. Finally, The Guide looks at behavioral health from the consumer perspective in terms of access to inpatient services, quality of care and the performance of the health plans in managing these services.

Overall, there are several trends that are having a profound impact on behavioral health financing, service system delivery and outcomes that are worth noting:

- National health care policy, specifically as related to Medicaid and Medicare, as well as current market trends establish the parameters for behavioral health financing and the behavioral health service delivery. With the majority of consumers with serious mental illness (SMI) covered by public payers, Medicaid and Medicare policy initiatives have the largest impact for this population.

- The national mental health market is moving towards a more comprehensive, value-based system of care. Federal policy is focused on developing better and more cost-effective use of available behavioral health funding to manage access, quality, and thus value of care. Alternative payment models, the end of the Institutions for Mental Disease (IMD) exclusion, coordination of care codes, and delivery system reform and modernization all seek to improve the delivery, integration, and reimbursement of care.

- Overall, health insurance coverage nationally has turned to managed care models to address cost, access, and quality of care. Virtually all individuals with commercial coverage and over 70% of individuals with coverage through Medicaid are in managed care plans. Currently, only about 30% of individuals with Medicare have opted into Medicare Advantage managed care plans.

- Medicaid is the primary payer for behavioral health services, and as the main payer serving the SMI population, state Medicaid programs serve as an important barometer for the behavioral health market. An examination of state-level policy finds two important trends – an increase in behavioral health financing integration into health plans and the emergence of consumer specific specialty health plans focused on the medical and behavioral health needs of the SMI population.

- State Medicaid programs have adopted a number of care coordination and integration initiatives that serve not only consumers with complex medical conditions, but also consumers with behavioral health conditions. There are 41 states with at least one behavioral health care coordination initiative including patient-centered medical home, health home, accountable care organization (ACO), dual demonstration, and certified community behavioral health clinic (CCBHCs) models.

- Behavioral health integration is becoming a greater priority as the health care system improves consumer access, customer satisfaction, and consumer engagement. Payers and providers are increasingly managing high-cost and high-risk groups through population health management innovations that close the gap between members' medical and behavioral needs through evidence-based practices and technologies that increase access to care and empower active individual participation in attaining health goals.

It is clear that national and state policies and practices have surpassed the initial efforts to advance behavioral health, underscoring a greater understanding of its effects on not just the cost of treatment, but more broadly on population health and wellness. The emergence of technology and evidentiary treatment models enable health systems to tailor value-based service delivery models that focus on the access and engagement needs of varying demography and chronic conditions. With these new provisions and innovations, there is more opportunity for person-centered and integrated high-quality health care to be placed firmly at the center of the new value equation.

The United States (U.S.) system for the financing and delivery of behavioral health services is in a state of flux. The market factors contributing to the concurrent developments in behavioral health are a complex combination of national policy, the unique effects of state governance and regulation in the United States, and the many organizations participating in the health and human services industry.

This opening section looks at the key U.S. policy issues and national trends in the health care system that are the framework for the financing and delivery of behavioral health services. Among these many factors, there are a few with direct and significant impact on behavioral health.

Over the past five years, we have seen a shift in the population distribution among payers at the national level, with a 40% reduction in the uninsured population and an increase in the Medicaid population as a direct result of the Patient Protection and Affordable Care Act of 2010 (PPACA).[1,2] The past five years have also seen a shift in the financial models being utilized by payers. The use of managed care financing models has increased in the nation by 24% across all payer types between 2011 and 2016 – with 76% of the total U.S. population enrolled in some form of managed care.[3]

While a number of factors have contributed to changes in the overall landscape of health care, many provisions of U.S. legislation and subsequent federal rules and regulations have had a large impact on the behavioral health care system in particular.[4] These policy initiatives are designed to promote better coordination of care, a more value-based system, and more comprehensive treatment options for consumers.

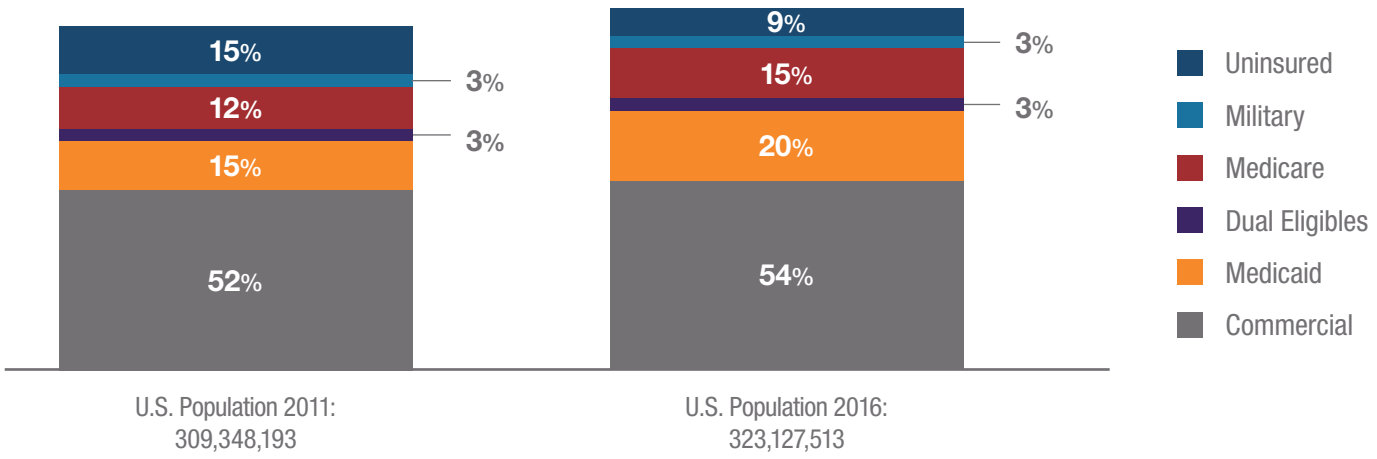
U.S. HEALTH CARE COVERAGE TRENDS

The Patient Protection and Affordable Care Act of 2010 (PPACA) has shaped the health care system over the past decade. While a change in the political climate may result in changes to the health care system in the short-term future, the system has already been irrevocably shaped by the PPACA. Over the past five years, we have seen a shift in the population health insurance coverage distribution among payers at the national level, as well as a change in the financing delivery models being utilized by payers.[1,5]

Health Insurance Coverage

Three major provisions of the PPACA legislation have influenced health care coverage throughout the country, and thereby changed the coverage map for consumers: the first was the option for states to expand their Medicaid programs to cover adults with income below 138% of the federal poverty level (FPL); the second was the creation of the health insurance marketplace, which allowed individuals and small businesses to shop for coverage; and third was the health insurance

Figure 1 U.S. Health Care Coverage, 2011 and 2016[1]



*Numbers may not add to 100%, as some consumers may have more than one type of health care coverage. For example, an individual may have primary commercial coverage from a private health plan and receive secondary coverage through Medicare.

mandate, which required all adults to have health insurance or pay a penalty.[6,7] As a result of these three major system changes, there has been significant change in how Americans receive health insurance coverage. The uninsured population has decreased by 40% between 2011 and 2016, while Medicare, Medicaid, and commercial populations have all seen an increase in covered populations. Medicaid has seen the single largest increase in the population covered with enrollment increasing 38% in between 2011 and 2016.[1]

Figure 2 Dual Eligibles with SMI, 2009[10]

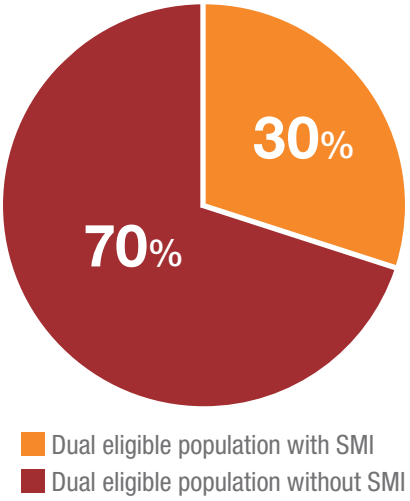
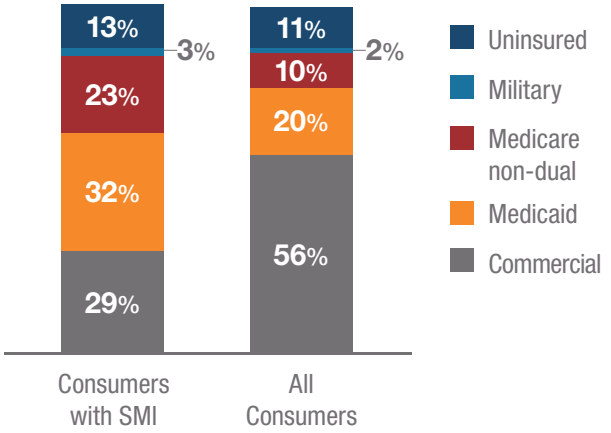


Figure 3 U.S. Health Insurance Coverage For Consumers With SMI, 2014[3]



*Numbers may not add to 100%, as some consumers may have more than one type of health care overage. For example, an individual may have primary commercial coverage from a private health plan and receive secondary coverage through Medicare.

Health Care Coverage and SMI Population

The health care coverage map for consumers with serious mental illness (SMI) differs from that of the general population. Consumers with SMI are defined as consumers age 18 and older with a diagnosable mental, emotional, or behavioral health disorder; meet the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders; and the disorder results in serious functional impairment. A majority of mental, emotional, or behavioral disorders have the potential to be categorized as SMI; however, schizophrenia and bipolar disorder are most commonly associated with the term.[8] Consumers with SMI are disproportionately served by public health care systems. As of 2014, the latest year SMI estimates are available, 58% of consumers with SMI were served by public insurance, 29% were served by private insurance, and 13% were uninsured. As a single payer, Medicaid has the largest proportion of SMI consumers at 32%. This percentage includes dual eligibles as Medicaid is the main payer of behavioral health services.[9] Among different groups of consumers, the dual eligible population has the highest prevalence of SMI—an estimated 30% of the population has a diagnosis of SMI.[10]

Managed Care Financing Models

Between 2011 and 2016, the use of managed care financing models has increased in the U.S. by 24% across all payer types—with 76% of the total U.S. population enrolled in some form of managed care. The use of managed care has increased most substantially among public payers, increasing almost 60% between 2011 and 2016. Comparatively, private payer use of managed care increased 13% over the same period.[3] This increase in managed care is due to a combination of factors, including a push to shift more services and populations to managed care financing models - and a desire from payers to delegate the management of care.[11]

Medicaid programs have seen the single largest increase (78%) in the number of consumers enrolled in managed care between 2011 and 2016. In 2011, 50% of the Medicaid population was enrolled in managed care, by 2016, 68% of the population was enrolled in managed care.[3] The use of Medicaid managed care has increased for a number of reasons including the need to stabilize state Medicaid costs, the shift to cover high-need and high cost populations through managed care, and the expansion of Medicaid to adults with income below 138% of the federal poverty level (FPL).[7,11] Medicare has seen a 52% increase in the use of managed care for enrollees, while the military population has actually seen a decrease of 17% in the use of managed care.[3]

Figure 4 Managing Care Financing Models

Payer Type	2011 Percent of U.S. Population Covered[3]	2016 Percent of U.S Population Covered[3]	2011 Percent of Population Enrolled in Managed Care[3]	2016 Percent of Population Enrolled in Managed Care[3]
Commercial	52%	54%	93%	98%
Medicaid	18%	23%	50%	68%
Medicare	16%	18%	25%	33%
Military	3%	3%	57%	49%
Uninsured	15%	9%	N/A	N/A
Total	**105%**	**107%**	**64%**	**76%**

*Numbers may not add to 100%, as some consumers may have more than one type of health care coverage. For example, an individual may have primary commercial coverage from a private health plan and receive secondary coverage through Medicare.

FEDERAL BEHAVIORAL HEALTH POLICY INITIATIVES

While a number of factors have contributed to changes in the overall landscape of health care, many provisions of U.S. legislation and subsequent federal rules and regulations have had a large impact on the behavioral health care system.[4] There are five major policy initiatives that will shape the mental health market over the next few years; these policy initiatives are designed to promote better coordination of care, a more value-based system, and more comprehensive treatment options for consumers.

Medicare Coordination of Care Codes

In January 2017, Medicare implemented a new coding and reimbursement system for behavioral health services integrated into primary care settings that are furnished via the Medicare psychiatric Collaborative Care Model (CoCM).[12] The psychiatric CoCM allows for interprofessional consultation between a psychiatrist or behavioral health specialist and the primary care clinician. Previously, care coordination activities between a psychiatrist or behavioral health specialist and the primary care clinician were "bundled" into the evaluation and management visit codes used by all specialties.[13] Provider organizations using psychiatric CoCM will bill using three G-codes (G0502, G0503, and G0504) until Current Procedural Terminology (CPT) codes are established possibly by 2018.[14] Although, these new codes are unlikely to change the way provider organizations operate, it does signal an emphasis by Medicare on integration of behavioral and physical health.

Alternative Payment Models in Medicaid and Medicare

In January 2015, the federal Department of Health and Human Services announced a goal of tying 90% of Medicare fee-for-service payments to quality by 2018 and 50% of payments to cost and quality by 2018.[15] Examples of advanced alternative payment models (APMs) currently being implemented by Medicare include Next Generation Accountable Care Organizations (ACOs), Comprehensive Primary Care Plus, and the Oncology Care Model. Additionally, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the sustainable growth rate for the Medicare physician fee schedule and replaced it with the Quality Improvement Program (QIP). Under QIP, clinical professionals will be required to participate in either advanced alternative payment models or the merit-based incentive program, which requires clinical professionals to report on quality in order to receive adjustments to their Medicare payments.[16] At this time, QIP does not include behavioral health provider organizations; however, participating clinical professionals may choose to report on behavioral health measures including anti-depressant medication management and depression remission at 12 months.[17] The Centers for Medicaid and CHIP Services has also issued encouragement to state Medicaid programs to implement alternative payment models. Examples of alternative payment models in Medicaid include ACOs, health homes, and episodes of care.[18] In 2011, Missouri implemented a health home initiative for adults and children with SMI. Community mental health centers receive a per member per

month (PMPM) rate to provide the six health home model care coordination functions.[19] As of January 2016, the program's cost savings were $98 per member per month (PMPM) and emergency room visits per 1,000 were down 34%.[20]

Institutions for Mental Disease (IMD) Medicaid Exclusion

In April 2016, the Centers for Medicare and Medicaid Services (CMS) finalized new managed care rules for the Medicaid program. Under the new rules, Medicaid health plans are able to care for consumers of any age in an Institution for Mental Disease (IMD) for up to 15 days as an "in lieu of" service. Prior to this, state Medicaid programs were prohibited from receiving federal funding for the provision of services in a facility with more than 16 beds where beds are primarily used to serve those with a mental illness or substance use disorder. Adoption of this new rule is dependent upon whether the state utilizes health plans or behavioral health organizations. To enact the rule, states must include IMDs as an "in lieu of" of service in the health plan contract. Health plans are not required to provide the service and consumers may refuse service in an IMD.[21]

Parity Legislation

In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) required private group plans to provide parity for mental health and substance use disorder benefits. Two years later, the Patient Protection and Affordable Care Act (PPACA) required parity for individual and small group plans, and in 2016, both the Department of Defense (DoD) and the Centers for Medicare and Medicaid Services (CMS) released final rules extending mental health and substance abuse parity to the TRICARE and Medicaid populations respectively. Parity does not require plans to cover mental health and substance abuse benefits. Parity requires that when a health plan offers mental health and substance abuse benefits, those benefits may not be more restrictive than medical/surgical benefits. Restrictiveness is measured through financial requirements, quantitative treatment limits, and non-quantitative treatment limits. Although parity has been implemented fairly recently, it has been suggested that parity has improved treatment rates for mental health and substance use.[22]

Public Health Care Safety Net

For individuals with SMI who are uninsured, the public health safety-net also serves as an important resource for receiving care.[2] The majority of care to the uninsured is provided in hospital based settings, followed by publicly supported community provider organizations, and then office-based physicians.[23] Under the PPACA and other federal initiatives, key changes are being made to how services are financed and delivered to individuals with SMI who are uninsured. First, under the PPACA, Disproportionate Share Hospital (DSH) payments to hospitals that serve a large number of low-income individuals are set to be reduced in fiscal year 2018. State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid and low-income patients. These payments are limited by annual federal allotments and funding differs greatly by state. States may make DSH payments to IMDs covering unpaid costs of care for uninsured individuals age 21 to 64. While the DSH reductions have been postponed in the past, these Medicaid program funds represent an important funding source for hospitals, which total $18 billion in 2014.[24]

At the community-based provider level, the Substance Abuse and Mental Health Services Administration (SAMHSA) has implemented a demonstration program in eight states that creates Certified Community Behavioral Health Clinics (CCBHCs) authorized under Section 223 of the Protecting Access to Medicare Act (PAMA), which are required to serve all individuals on a sliding scale regardless of their ability to pay.[25,26] CCBHCs are also eligible to receive enhanced Medicaid funding for reimbursable behavioral health services through the Prospective Payment System (PPS). Drawn from requirements on federally qualified health centers and other Medicaid programs, the CCBHCs are an important signal towards a nationally recognized mental health community-based provider system.[27]

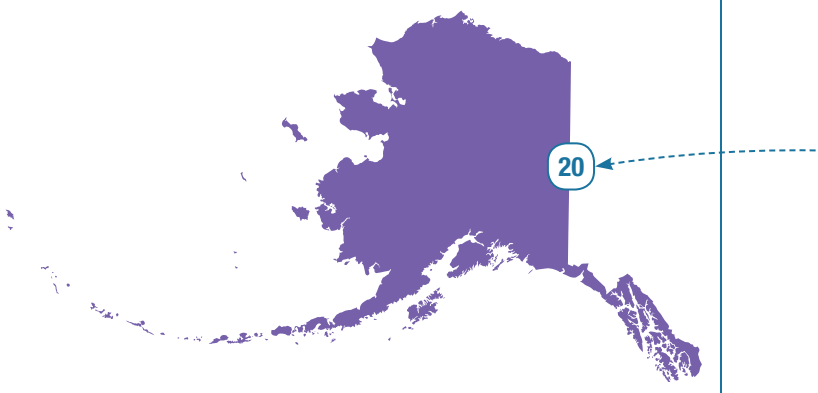
Looking Forward at the Health Care Landscape

There are ongoing attempts to repeal or replace parts of the PPACA. Upon going to press with this report, the future of these legislative attempts is uncertain. Possible changes to the PPACA might include ending the Medicaid expansion, moving Medicaid financing to block grants or per capita funding, giving states more flexibility in running their marketplaces, imposing penalties on those who do not maintain continuous coverage, and substitute aged-based subsidies for means-based subsidies on the marketplace.[28]

In addition to reforms enacted by Congress, the federal Department of Health and Human Services (HHS) also has the opportunity to make smaller regulatory reforms that alter the PPACA. On February 17, 2017, the HHS released a proposed rule on the health insurance marketplace that truncates the

open enrollment period, amends standards for the special enrollment period, returns network adequacy standards to the states, and increases the de minimis variation between some health plan medal levels.[29] A letter from the Secretary of HHS and the CMS Administrator also indicate changes to state Medicaid programs including, a faster more transparent process for waivers and state plan amendments, supporting innovative approaches to increase employment and community engagement, and aligning Medicaid and private insurance policies for non-disabled adults.[30]

Figure 5a



VETERANS AND BEHAVIORAL HEALTH CARE

The Veterans Administration (VA) provided health care services to 6.0 million veterans in 2015 or 69% of the total 9.6 million veterans eligible to receive health care services.[31] The gap in coverage is due to the fact that many veterans have other forms of coverage, such as private insurance, TRICARE, Medicare, etc.[32]

The VA is an integrated health care system providing the majority of health care services in VA operated medical centers and outpatient sites.[33] The system breaks the country into Veterans Integrated Service Networks (VISNs), which oversee the operation of VA facilities in its defined geographic region.[34] The VA provides a full continuum of mental health services including inpatient, outpatient, and specialized treatment for post-traumatic stress disorder (PTSD).[35] In the past ten to 15 years, the VA has increased the number of facilities offering outpatient care. In 1995, the VA issued a directive to expand the number of community-based outpatient clinics (CBOC). The clinics could either be operated by the VA or contracted to a private clinic, group practice, or single practitioner. At the time of the directive there were 172 hospitals and 175 CBOCs. The majority of clinics were opened between 1998 and 1999 when 124 new CBOCs were opened.[36] In 2016, there were over 755 CBOCs and 144 hospitals.[37]

Over the past ten years, the number of veterans receiving mental health care through the VA has increased from 900,000 in 2006 to 1.52 million in 2015. This is an increase of 69%. The majority of that increase in mental health care came between 2006 and 2010, when care increased by 74%. After 2010, the number of veterans receiving mental health care stabilized around 1.55 million.[38]

In 2012, the VA found that there were longer than acceptable wait times for accessing mental health services and that VA tracking of wait times was inaccurate. VA standards state that veterans must be seen for an initial evaluation within 24 hours and a comprehensive diagnostic and treatment planning evaluation within 14 days.[39] In the past two years, the VA has made very little progress in lowering mental health wait times. As of October 2014, when the VA began publicly reporting wait times, the average wait for mental health treatment was 4.11 days and in March 2017, the average wait time was 4.06 days.[40]

In order to alleviate staffing problems, the VA implemented a mental health hiring initiative in 2012. The initiative's goal was to bring all facilities up to the VA average of 7.72 full-time clinical mental health staff (FTE) per 1,000 patients.[41] As of 2016, some facilities are still working to reach this goal. By 2021, VA analysis finds that an additional 3,712 FTE mental health clinical staff will be needed.[42]

In order to address these issues, the VA implemented the Veterans Choice Program, which allows veterans who are not able to schedule an appointment within 30 days of their preferred date, within the clinically appropriate time frame, or on the basis of their residence to schedule an appointment with a provider organization outside of the VA.[43]

Figure 5a Veterans Integrated Service Network Map[44]

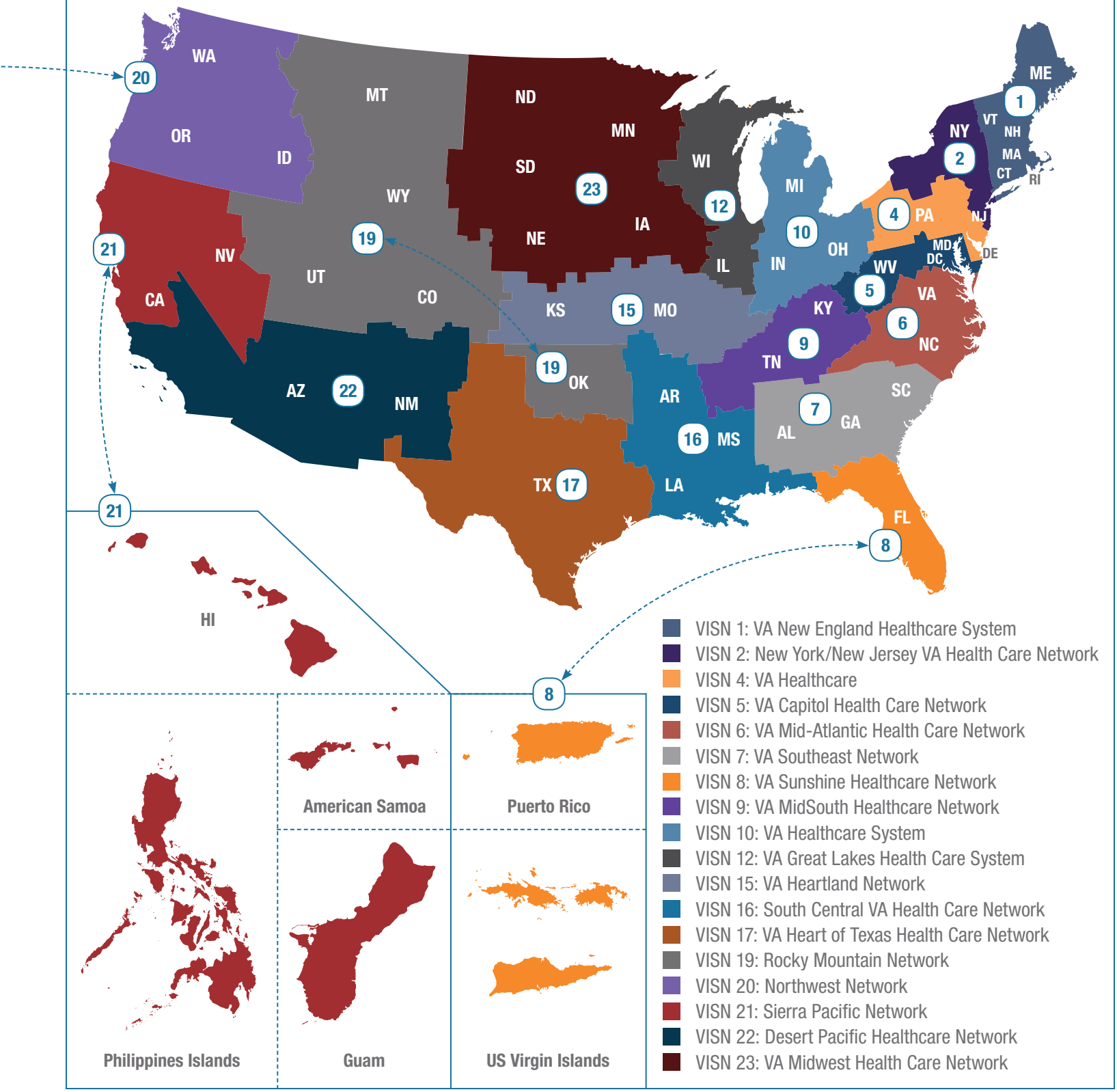


Figure 5b Veterans Health Administration[45]

VISN	1	2	4	5	6	7	8	9
States Served*	CT, MA, ME, NH RI, VT	NJ, NY, PA	DE, NJ PA, WV	MD, VA, DC	NC, SC VA, WV	AL, GA, SC	FL, GA PR, VI	AL, AR, GA IN, KY, OH TN, VA, WV
Number Users with Possible Mental Illness	88,075	98,657	100,875	44,927	135,044	158,283	190,943	113,451
Medical Centers	11	14	10	8	7	9	7	7
Outpatient Clinics	4	1	1	2	7	8	14	7
Community-based Outpatient Clinics	40	59	44	27	28	47	51	39
Psychiatrists	239	249	150	120	221	256	379	147
Mental Health Nurse Practitioners	10	13	2	8	3	5	25	7
Number of Veterans who Accessed Mental Health Services	65,291	31,521	74,434	40,864	107,157	124,304	154,116	82,494
Average Wait Time for Mental Health Care (days to appointment)	3.24	2.97	4.07	4.73	5.34	5.5	3.61	3.86

* AL – Alabama, AK – Alaska, AZ – Arizona, AR – Arkansas, CA – California, CO – Colorado, CT – Connecticut, DE – Delaware, FL – Florida, GA – Georgia, HI – Hawaii, ID – Idaho, IL – Illinois, IN – Indiana, IA – Iowa, KS – Kansas, KY – Kentucky, LA – Louisiana, ME – Maine, MD – Maryland, MA – Massachusetts, MI – Michigan, MN – Minnesota, MS – Mississippi, MO – Missouri, MT – Montana, NE – Nebraska, NV – Nevada, NH – New Hampshire, NJ – New Jersey

10	12	15	16	17	19	20	21	22	23
IN, KY, OH	IA, IL, IN MI, WI	AR, IL, KS KY, MO	AL, AR, FL LA, MO, MS TX	OK, NM, TX	CO, ID, KS MT, NE, NV UT, WY	AK, ID, MT OR, WA	CA, NV, HI PH, GU, AS	AZ, CA CO, NM	IA, IL, KS MN, MO, ND NE, SD, WI WY
154,019	90,848	82,721	183,057	136,834	69,013	101,185	91,135	185,406	91,240
12	8	9	9	5	3	6	8	4	2
2	38	5	1	19	20	11	26	12	2
59	8	52	49	30	51	34	23	58	59
251	176	99	196	205	133	147	193	312	146
21	1	6	6	1	1	17	8	9	6
64,899	62,448	60,945	143,119	91,581	53,345	70,960	74,565	101,437	64,626
3.18	3.79	3.78	3.87	4.93	4.21	3.07	4.42	5.23	3.22

NM – New Mexico, NY – New York, NC – North Carolina, ND – North Dakota, OH – Ohio, OK – Oklahoma, OR – Oregon, PA – Pennsylvania, RI – Rhode Island, SC – South Carolina, SD – South Dakota, TN – Tennessee, TX – Texas, UT – Utah, VT – Vermont, VA – Virginia, WA – Washington, WV – West Virginia, WI – Wisconsin, WY – Wyoming, AS – American Samoa, DC – District of Columbia, GU – Guam, PH – Philippines Islands, PR – Puerto Rico, VI – Virgin Islands