

Trends in the Provision of Emergency Department Evaluation & Management Services

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Emergency Department Evaluation and Management Coding

Executive Summary

Health care policymakers have noted a shift in the intensity level of evaluation and management (E/M) services provided to Medicare fee-for-service (FFS) beneficiaries in hospital emergency departments (EDs). The American Hospital Association (AHA) asked The Moran Company (TMC) to examine these trends.

In analyzing this issue, we found that the use of E/M codes indicating a higher level of service intensity has increased in recent years; we then examined possible drivers of this shift. We examined ED E/M volume and coded service intensity in the outpatient setting from 2006-2011, and the patient characteristics of beneficiaries receiving such care from 2006-2010.

Regarding coding intensity, we found:

- Increasing volume of ED E/M codes throughout FFS Medicare; and
- Increasing proportions in the higher severity levels.

We also found a number of shifts in the types of beneficiaries being treated in the ED, which may explain the increase in the severity levels coded:

- More FFS beneficiaries are receiving ED E/M services;
- The average number of ED visits per beneficiary is increasing;
- Patients receiving E/M services are getting sicker – as measured by an increase in Hierarchical Condition Category (HCC) scores;
- ED visits that include an observation stay are increasing. Observation stays may be used as a substitute for inpatient admissions and have a significantly higher mix of service intensity;
- Beneficiaries aged 64 and younger have more ED visits than any other age group;
- People that have both Medicare and Medicaid coverage (dual-eligible status) are using more ED E/M services over time; these individuals have higher severity levels on average; and
- The number and proportion of beneficiaries with behavioral health diagnoses and ED E/M visits is increasing. These beneficiaries have a significantly higher mix of service intensity.

Introduction

There have been recent policy discussions about growth in the volume and intensity level of emergency department (ED) evaluation and management (E/M) services provided to Medicare fee-for-service (FFS) beneficiaries. The Moran Company (TMC) was asked to research trends in the use of ED E/M services, and to explore factors that may be driving the shift to higher intensity level codes.

In the discussions, policymakers have noted two related issues: the growth in the volume of E/M services and the shift in the mix of codes indicating lower resource utilization to those indicating higher resource utilization. The ED codes at issue are: Current Procedural Terminology (CPT®) 99281-99285, which correspond to Level 1 through Level 5 ED visits, and G0380-G0384, which are similar codes used in Type B EDs.¹ The codes indicating a higher level of service intensity are the ones at the upper end of each range.

Hospitals have been using the CPT® E/M codes to report facility resources used to treat patients in the ED since April 2000. Facility resources include such things as time spent by nurses and other hospital-staff in caring for patients and a variety of interventions performed by nursing or ancillary staff (e.g., administration of medication, wound cleaning, cardiac monitoring, catheter care, etc.). Recognizing that the E/M code descriptors, which were designed to reflect the activities of physicians, did not adequately describe the range and mix of services provided by hospitals, the Centers for Medicare & Medicaid Services (CMS) instructed hospitals to develop internal hospital guidelines to determine the level of ED services provided.

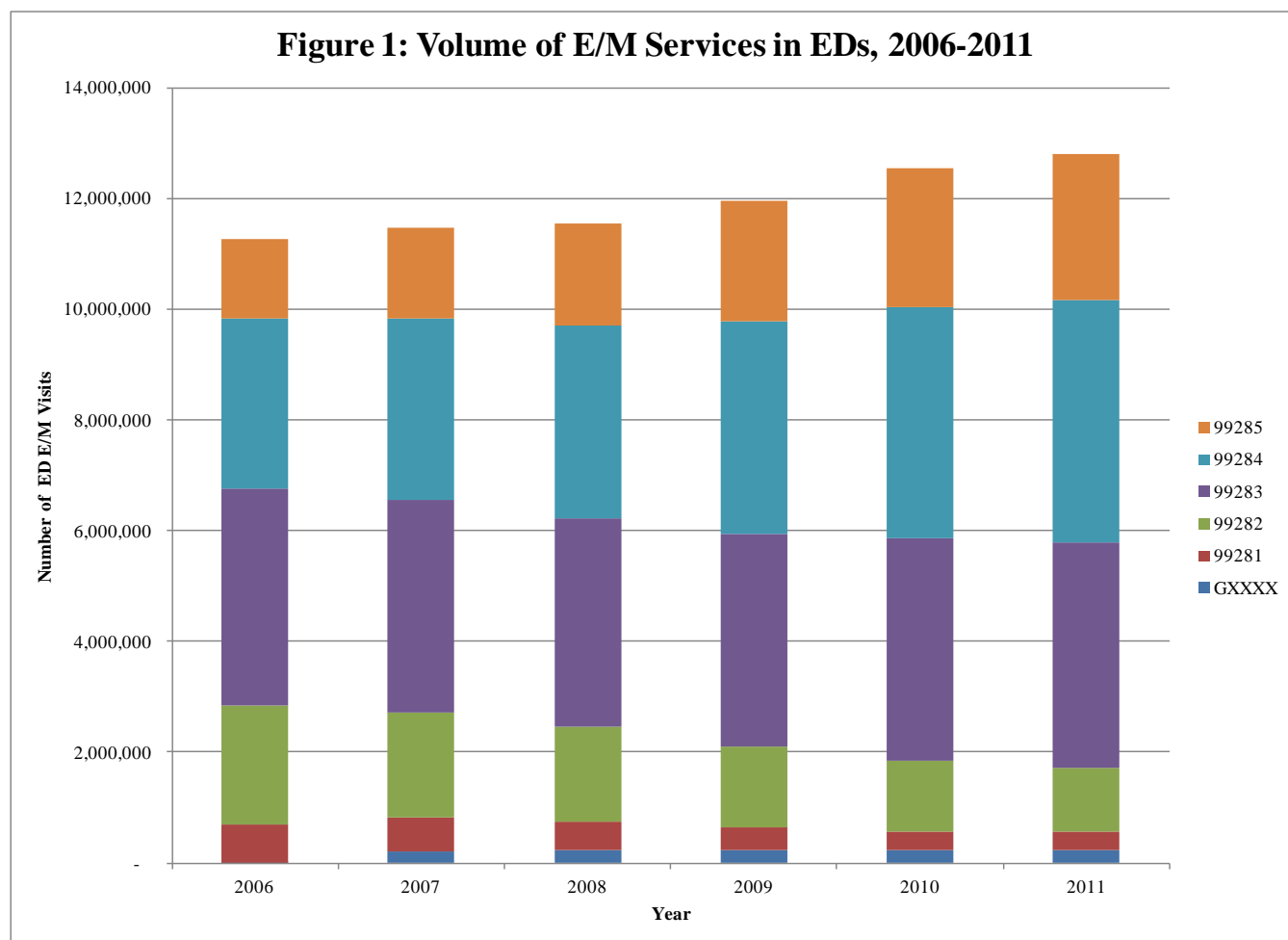
In 2003, the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) recommended that CMS implement national hospital E/M visit guidelines based on the work of an independent expert panel comprised of representatives with coding, health information management, documentation, billing, nursing, finance, auditing and medical experience. Unfortunately, although the CPT manual provides some guidance, CMS still has not provided any national guidelines with specific and clear criteria to determine the appropriate code level. CMS continues to instruct hospitals to report ED visits according to their own internal hospital guidelines to determine the different levels of ED visits.

Most of our discussion will focus on the 99281-99285 series, as the G0380-G0384 has relatively low volume compared to the other codes. In our code level analysis, we have usually grouped all of the G-code series of codes together.

¹ CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

The number of ED visits with E/M services has been increasing over time. Figure 1 displays the increasing number of ED E/M visits, broken down by code.

The volume and intensity level of ED visits has increased over time.

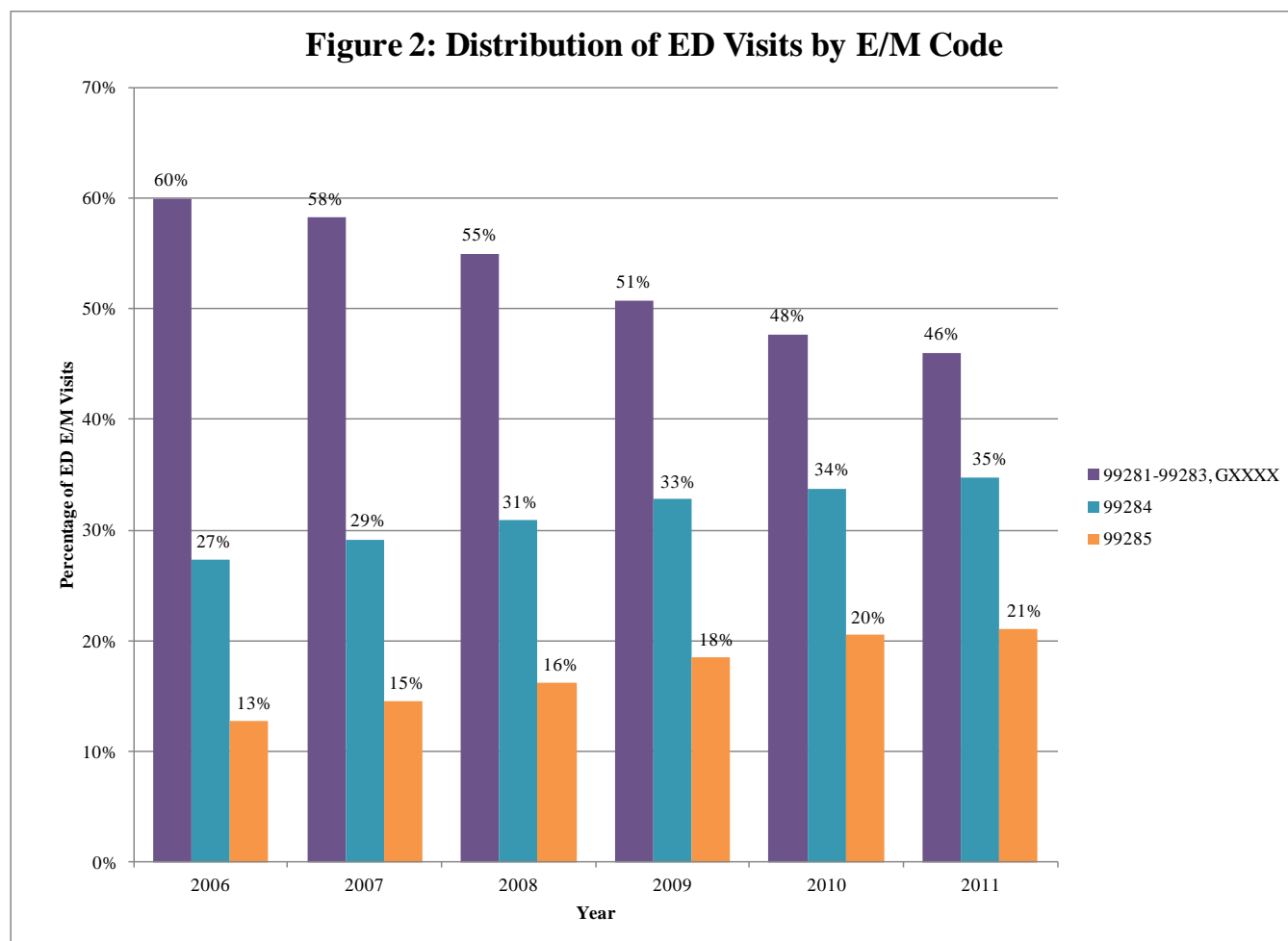


Note that the 2011 data are based on the proposed rule rate-setting file and, therefore, result in an undercount of the final volume. All other years represent the final rule data, which include six months of additional data. With the release of the 2011 final rule data, we expect the 2011 figure to increase.² Nonetheless, even with the partial data set, the volume of ED E/M codes billed over the 2006-2011 time period increased by an average of 2.7 percent per year (the average percentage change in volume of ED E/M codes each year is shown in Table 1 in Appendix B).

² The final rule data were released after the analysis for this report was completed, but before the report's final publication. Looking at the final rule data, we found that for the ED E/M codes we studied, there was an 8% increase in volume from the 2011 proposed to 2011 final rule data.

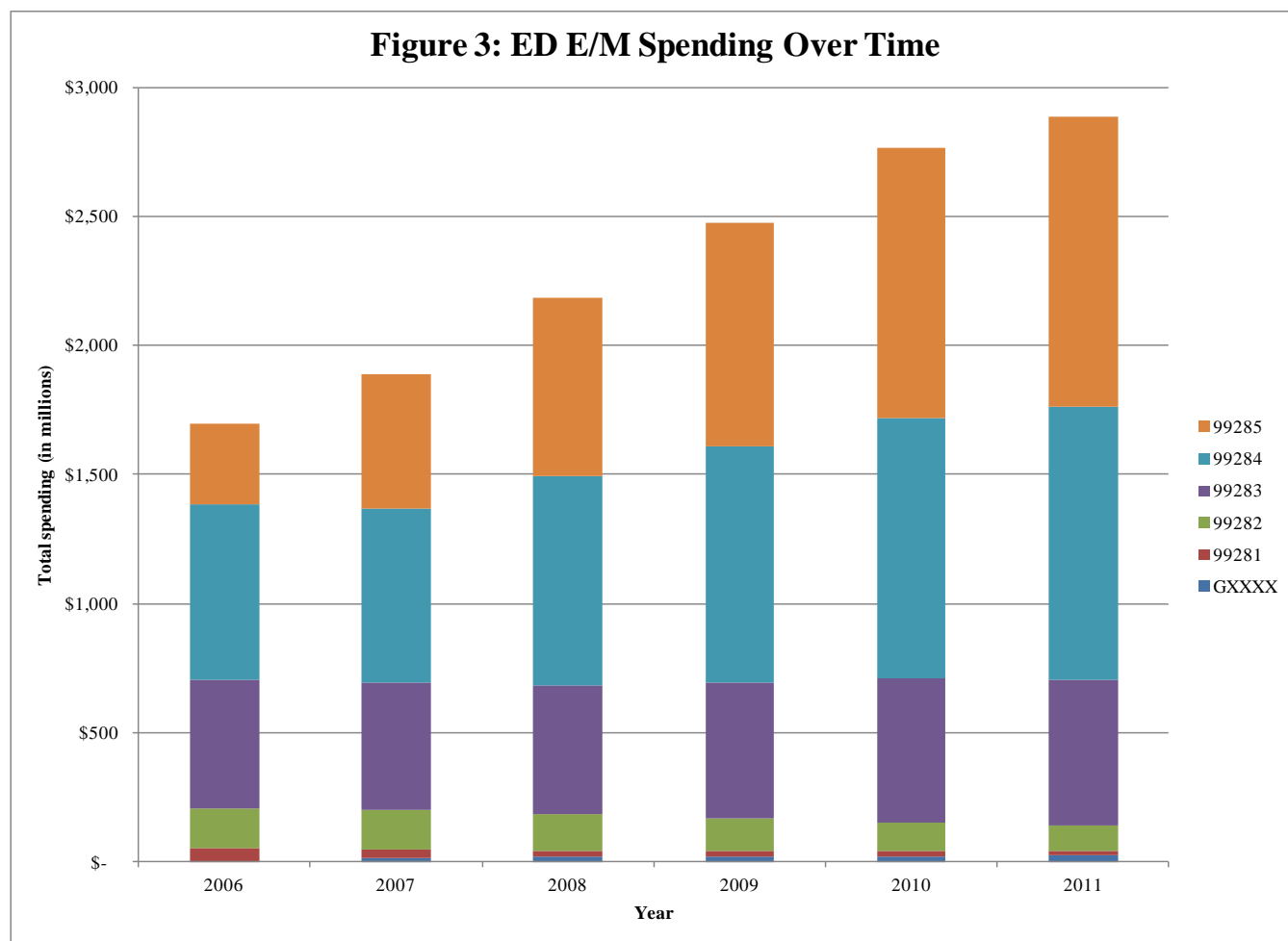
In addition to the increase in the volume of ED E/M visits, Figure 2 shows the shift in intensity level from the lower level E/M codes to the higher level codes. In particular, codes 99284 and 99285 show a marked increase.

The intensity of Medicare services provided in the ED has increased over time.



The combination of increased volume of ED E/M visits with the use of codes indicating a higher level of service intensity leads to increased spending – aggregate payments to providers, since the higher level codes are reimbursed at a higher rate.³ This spending over time is shown in Figure 3 below.

Greater volume and intensity of services has led to increased spending.



Note that the 2011 volume is based on incomplete (proposed rule) data and as indicated in footnote 2, volumes did increase in the final rule data.

³ Aggregate payments to providers includes both payments from Medicare and the beneficiary share.

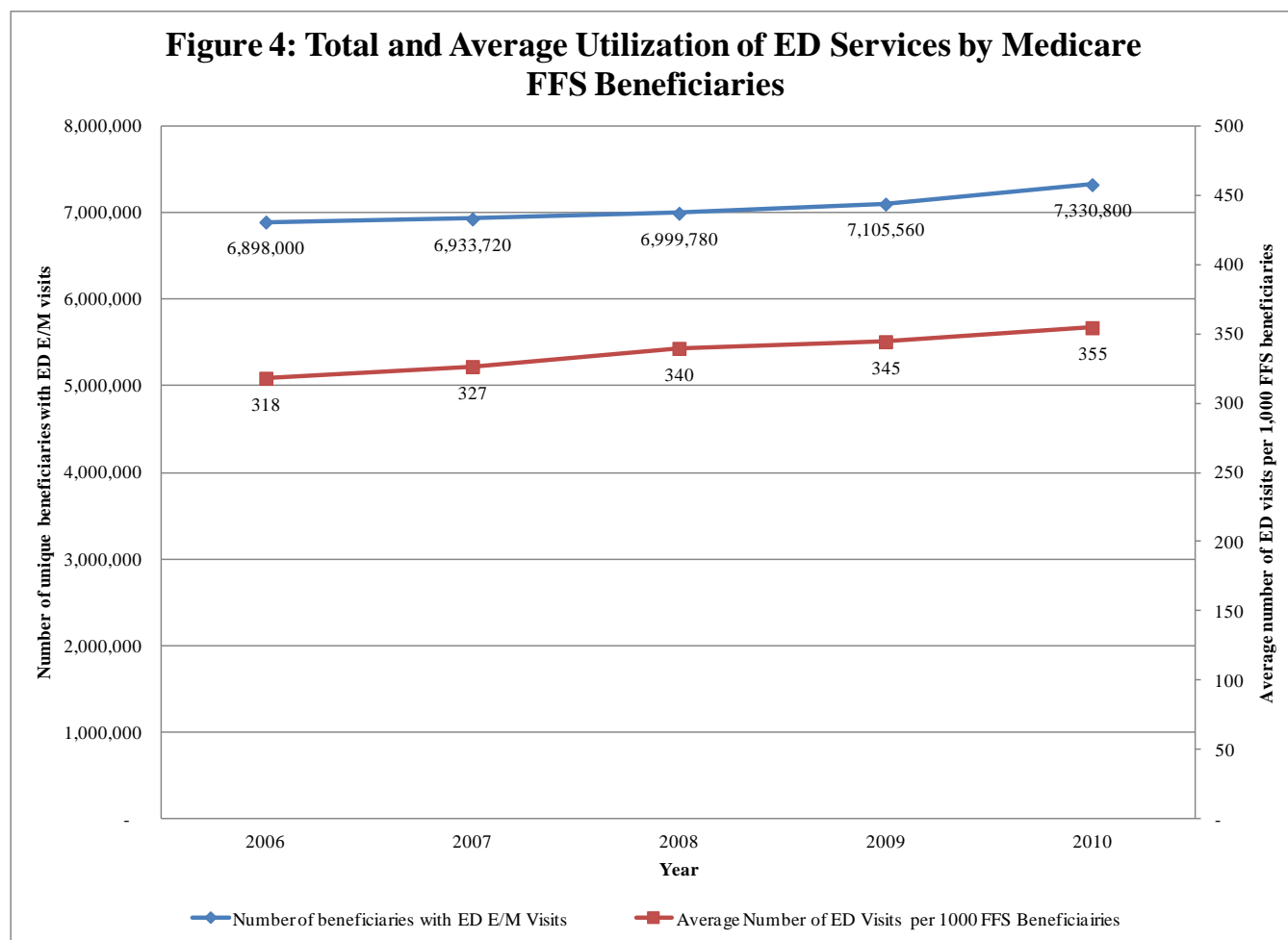
Findings

In addition to tracking the volume of ED E/M services and the associated spending, we explored a number of factors that may be driving these trends.

Number of Beneficiaries and Visit Characteristics

The increase in ED volume for Medicare beneficiaries is both a function of an increase in the number of beneficiaries and more use of ED services per beneficiary. Over this time period, the FFS Medicare population has grown by nearly 4 million beneficiaries and the number of beneficiaries seen in the ED increased by 432,800. In addition, the number of ED visits per Medicare FFS beneficiary rose by nearly 12 percent between 2006 and 2010. See Figure 4.

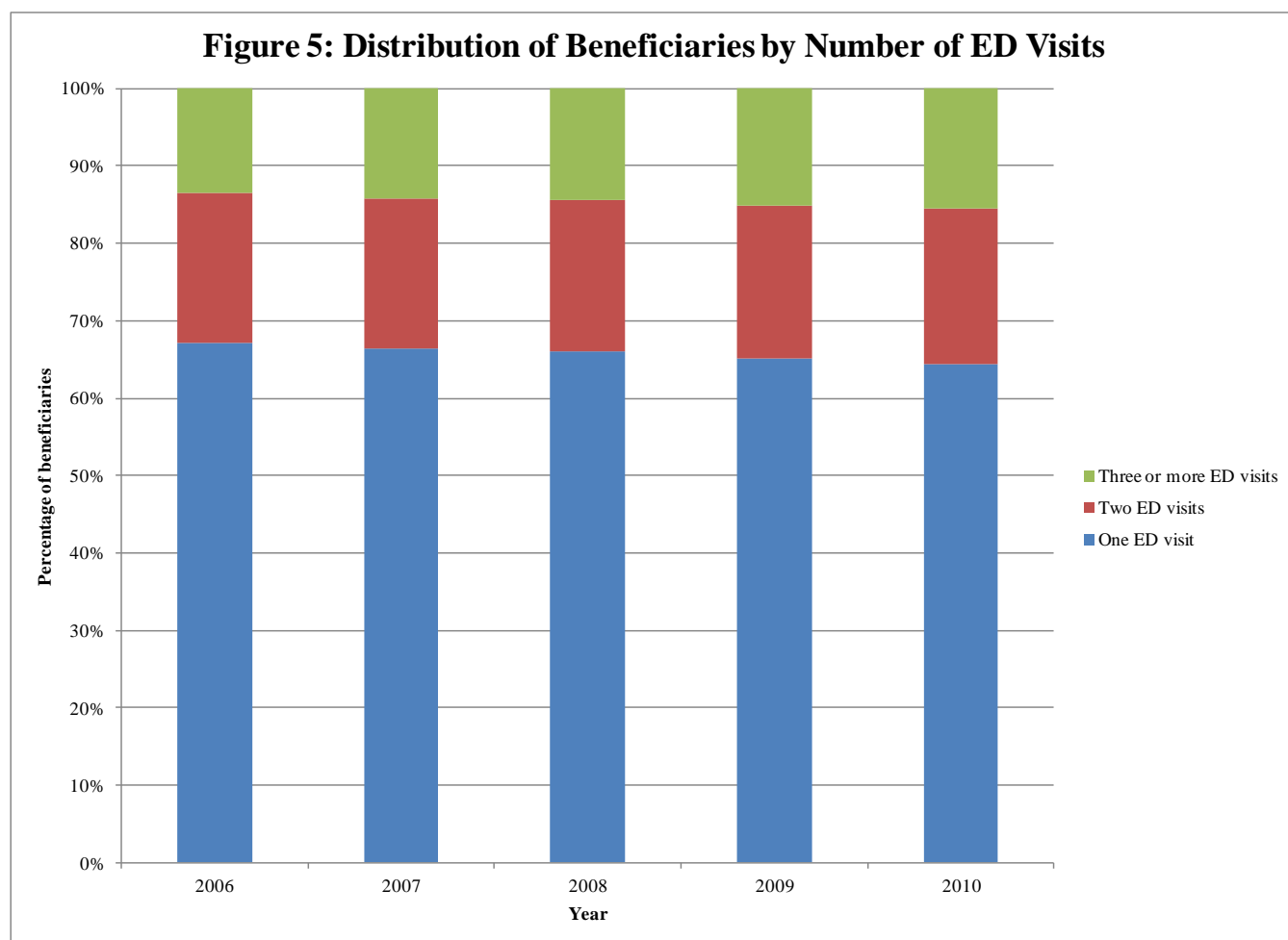
The number of beneficiaries using ED services is increasing as is the number of services used per beneficiary.



In addition to more beneficiaries using the services, the beneficiaries using the ED services are visiting the ED more frequently, perhaps due to rising acuity levels (see below) or a lack of access to other types of medical care. The mean number of visits per beneficiary with at least one ED visit has increased by nearly 6 percent from 2006 to 2010 (Table 2 in Appendix B).

The percentage of beneficiaries with a single visit dropped from 67.1 percent to 64.4 percent over time, while the percentage with three or more visits increased from 13.5 percent to 15.5 percent. See Figure 5.

The percentage of beneficiaries with three or more ED visits has increased over time.



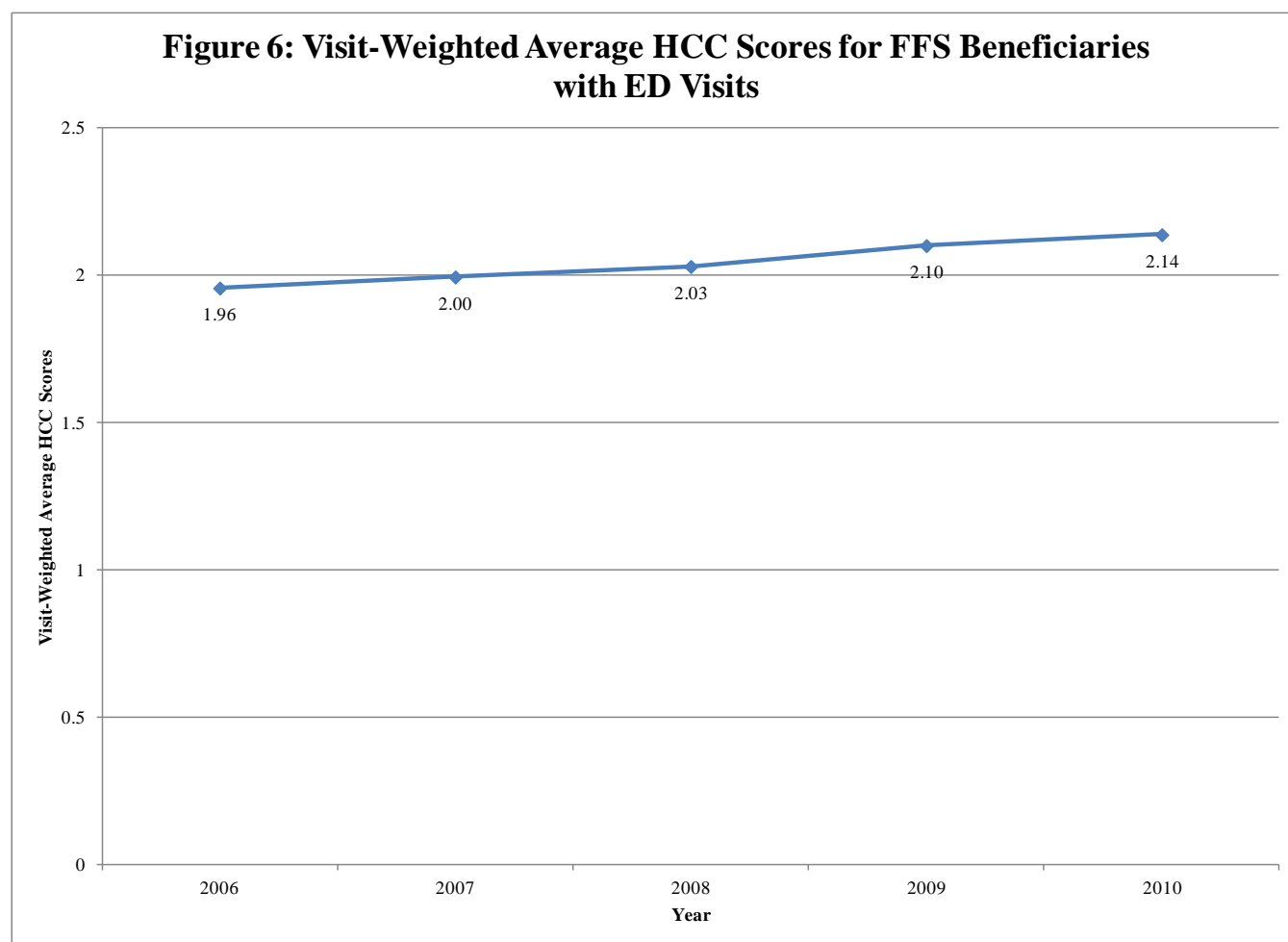
Severity of Illness

The increase in use of the more intensive codes over this time period coincides with an increase in patient severity. In this section, we will present information based on our analysis using CMS Hierarchical Condition Category (HCC) scores. HCC scores were developed by CMS to measure expected resource utilization for risk adjustment in the Medicare Advantage program. HCC scores are calculated based on all of the diagnoses reported for a beneficiary in a year across the inpatient,

outpatient, and physician office settings, as well as patient demographics. An HCC score is a numerical value used to represent a patient's expected resource utilization in the future. As such, HCC scores are often used as a proxy for patient severity. Higher HCC scores represent more severe and resource-intensive health care needs.

For our analysis, we calculated each beneficiary's HCC scores for each year the beneficiary had an ED visit. We used the same set of HCC weights across all years, which allowed us to capture changes in a beneficiary's health status over time.⁴ We found that the average HCC score rose by 9 percent over the 2006-2010 time period, suggesting that patients using the ED have increasingly more complex health care conditions (Figure 6).⁵

Medicare beneficiaries receiving care in the ED are getting sicker.



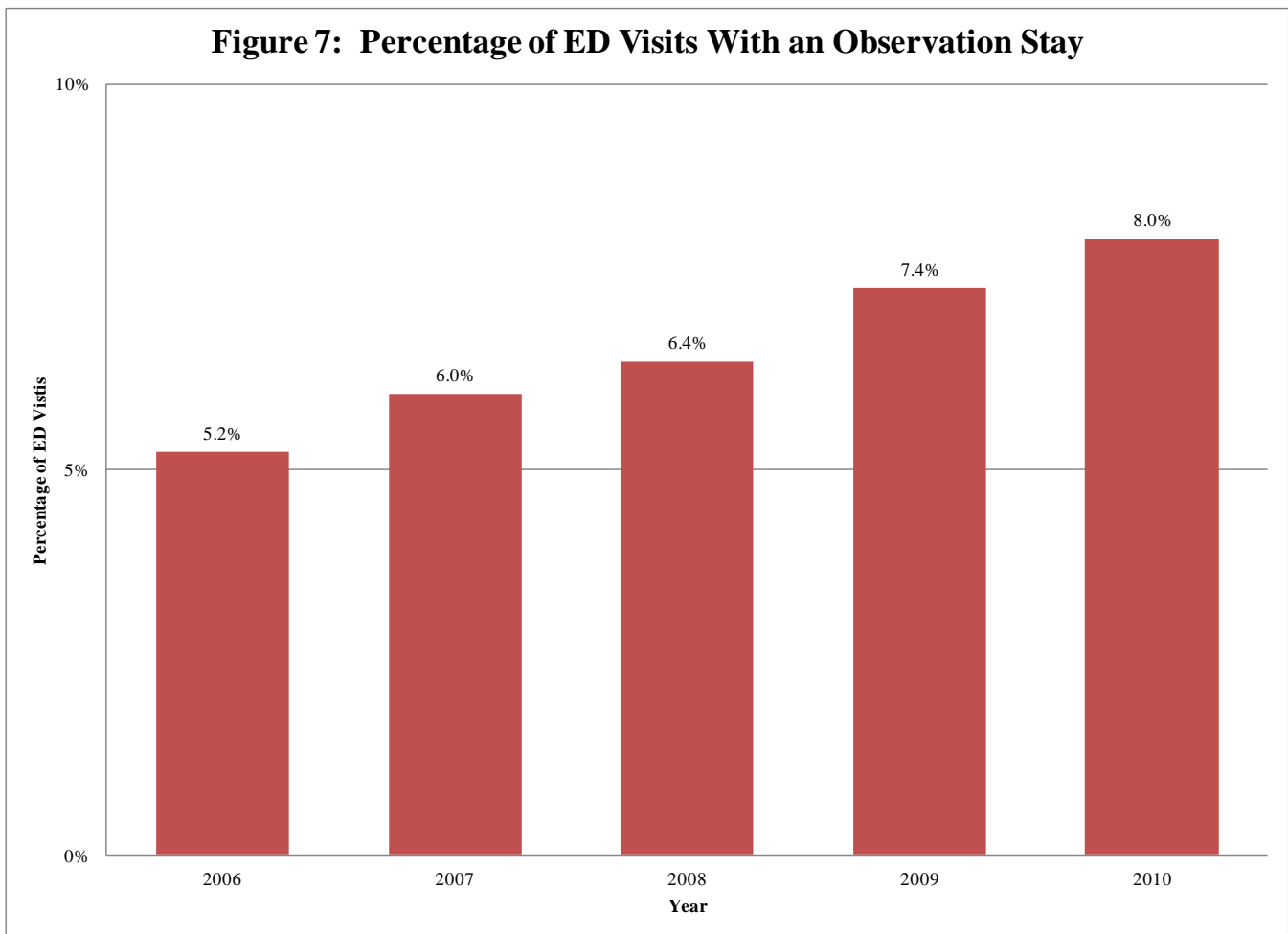
⁴ In order to determine HCC scores for beneficiaries in 2006-2010, we used data from the same year as opposed to the previous year (as generally used in the CMS HCC model). For example, for 2008 HCC scores, we used information based on their 2008 claims. The purpose here was to use HCC as a measure of patient severity in the given year, and not as a predictor of future utilization as the model is used by CMS for future risk adjustment.

⁵ For this analysis, we calculated the visit-weighted average HCC score, as opposed to the beneficiary-level average HCC score.

Observation Stays

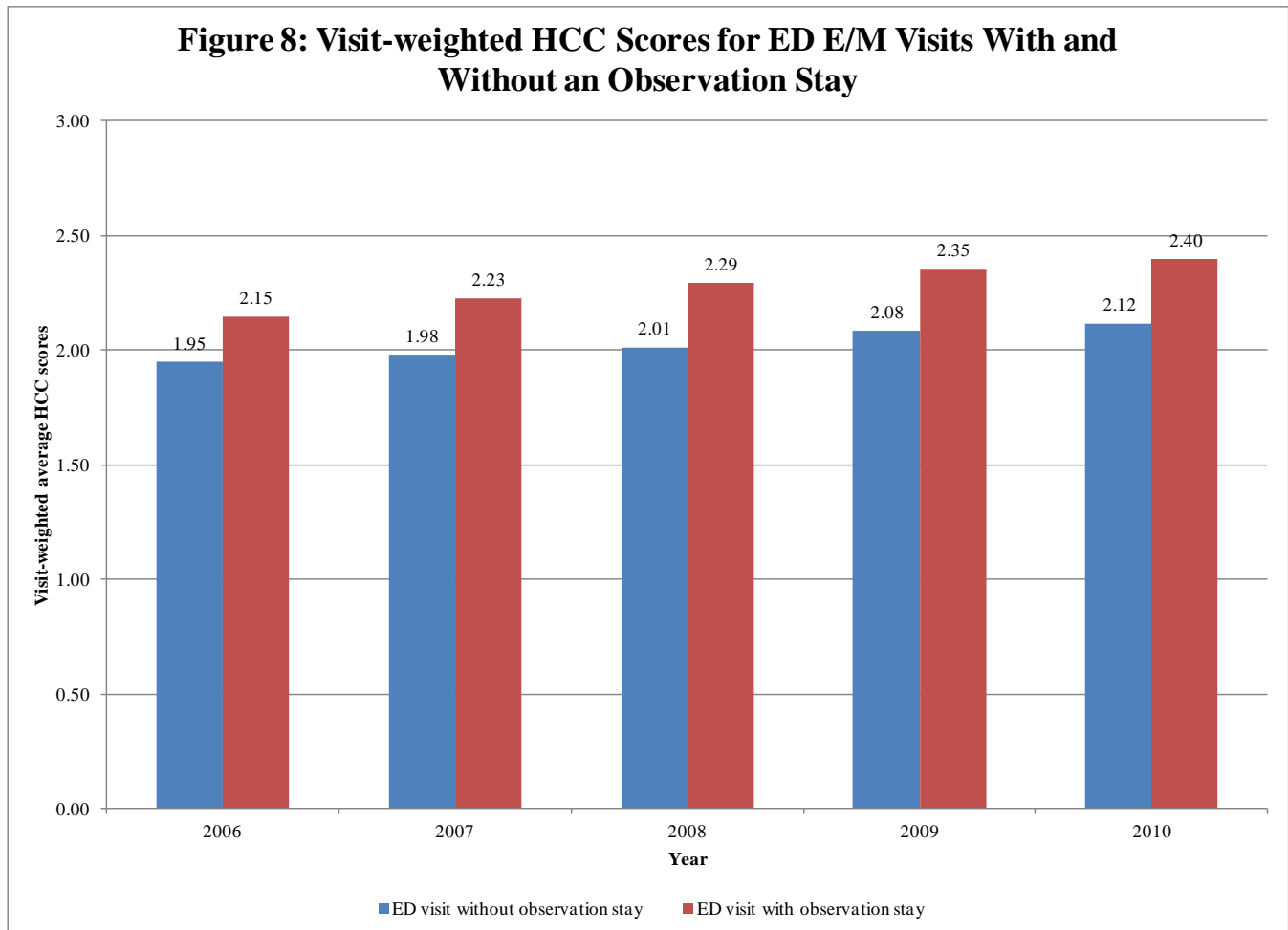
The volume and percentage of ED visits with an observation stay has increased by approximately 72 percent and 54 percent from 2006 to 2010. This may largely be a result of heightened scrutiny of short-stay inpatient admissions by Medicare auditors. These auditors are increasingly denying payment for short-stay inpatient admissions retrospectively, claiming that these services could have been provided in an outpatient setting. This trend has put pressure on hospitals and physicians to order outpatient observation care for patients who would have previously been admitted to an inpatient unit. As a result, the incidence of observation services is on the rise. This is important because had the person instead been admitted to the hospital as an inpatient, these claims would have shifted to the inpatient prospective payment system and would not appear in the outpatient data. In addition, the presence of observation stays is another proxy for patient severity. Patients with observation stays receive a higher level of E/M care than the typical outpatient. Thus, growth in the share of patients with observation stays contributes to an increase in overall coded intensity. See Figure 7.

The percentage of ED visits with observation stays has increased by more than 50 percent.



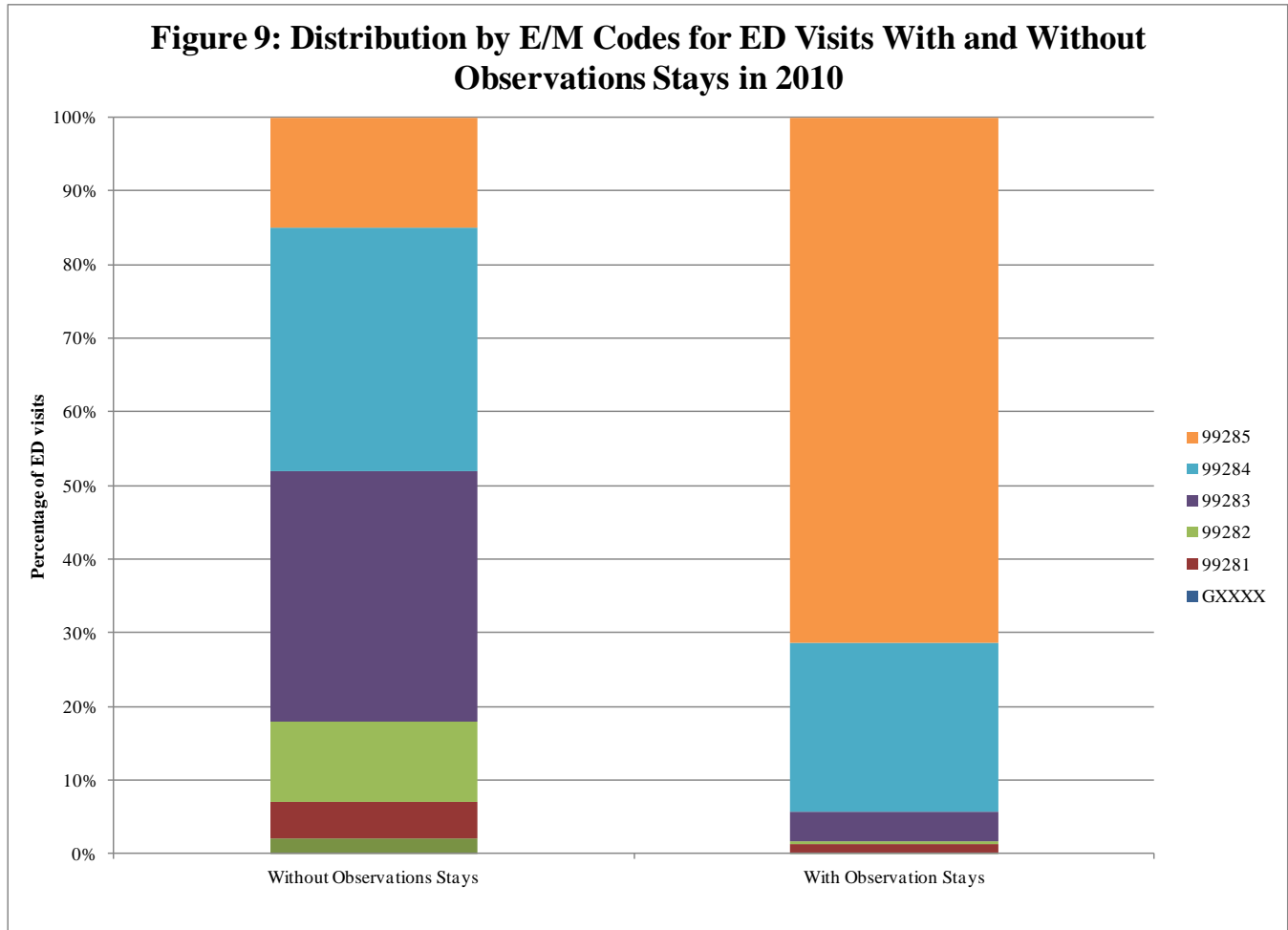
As can be seen in Figure 8, the average severity of cases (measured using HCC scores) with observation stays is consistently higher over time than the average severity without observation stays. The severity level of observation patients also has increased as more inpatient volume has shifted to this setting.

Beneficiaries receiving observation care are sicker than other ED patients.



The mix of ED E/M codes billed on claims with observation stays is noticeably different from the mix billed on claims without observation stays and heavily weighted to the higher level codes, as shown in Figure 9.

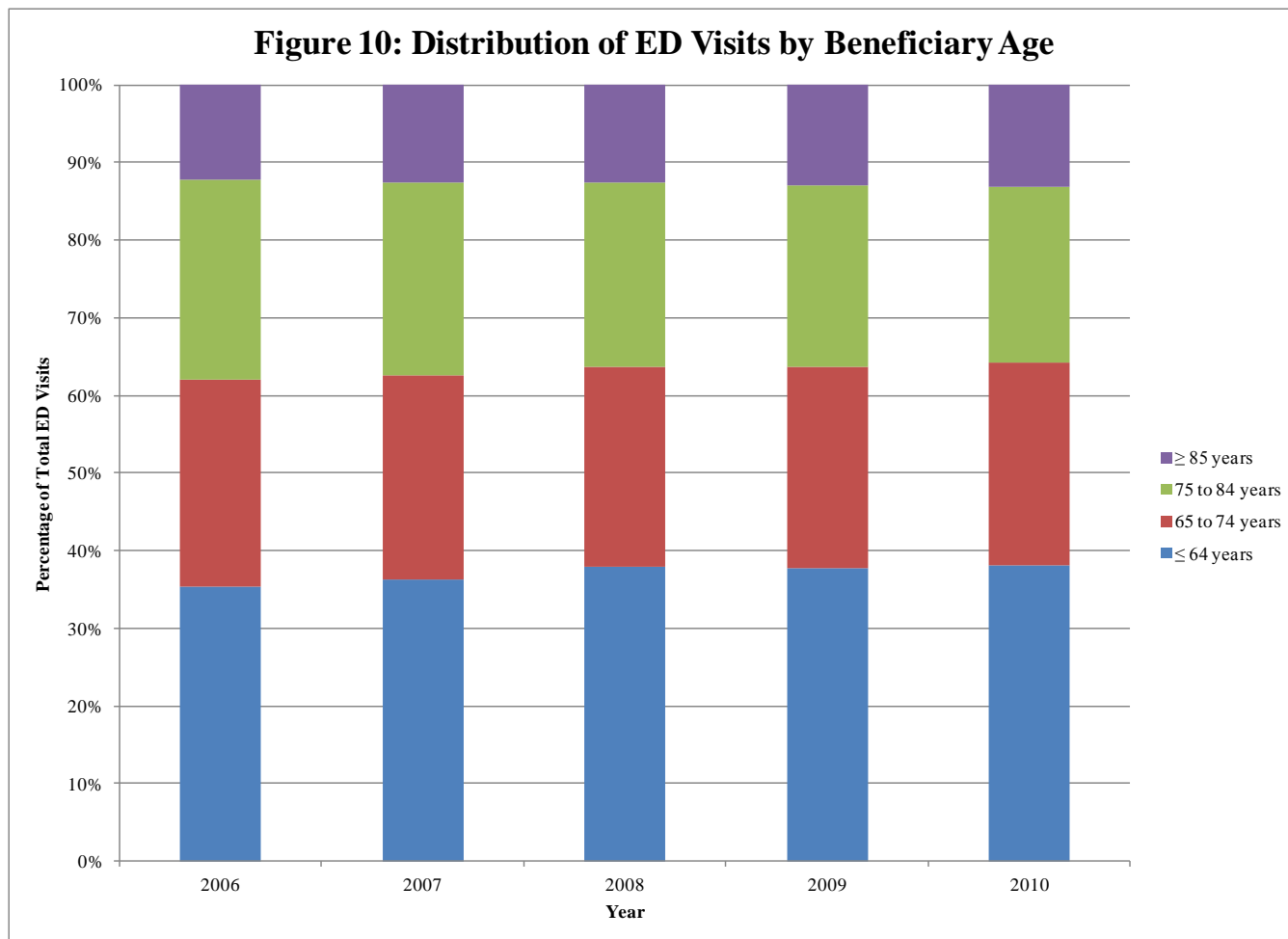
The mix of service intensity is significantly higher for ED observation stay patients.



Characteristics of Patients Receiving Care in the ED

Our analysis suggests that the increase in severity in the ED patient population is not driven by the aging of the Medicare population. The average age of beneficiaries using the ED has actually declined slightly (the visit-weighted mean age has decreased from 66.5 in 2006 to 65.7 in 2010; Table 3 in Appendix B). A detailed breakdown of the age distribution can be found in Figure 10.

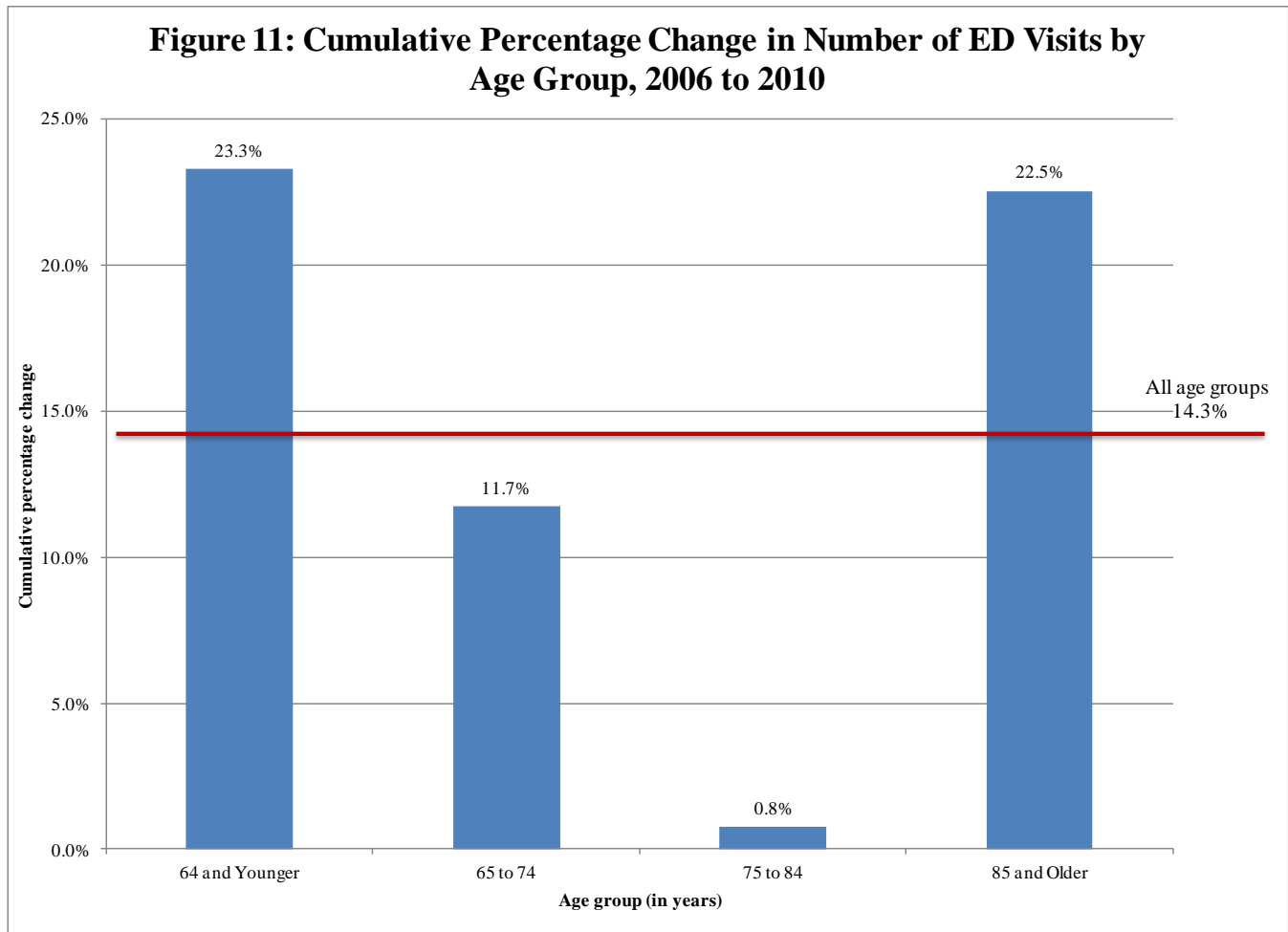
The percentage of ED visits accounted for by the non-aged population is rising.



As can be seen in Figure 10, the percentage of ED visits by beneficiaries age 64 and younger has increased from 35.4 percent to 38.2 percent. From 2006 to 2010, utilization for beneficiaries age 64 and younger has grown by 23 percent, compared to a 14 percent growth in utilization among all age groups. Beneficiaries over 85 also had a 23 percent growth in utilization and showed an increase from 12.2 percent to 13.0 percent in the percentage of ED visits over the study period. See Figure 11. The population of beneficiaries age 64 and younger uses a disproportionate share of Medicare ED E/M services, perhaps indicating more complex needs. In 2010, while beneficiaries age 64 and younger

made up 38 percent of those using ED E/M services, they made up only 17 percent of Medicare beneficiaries.⁶

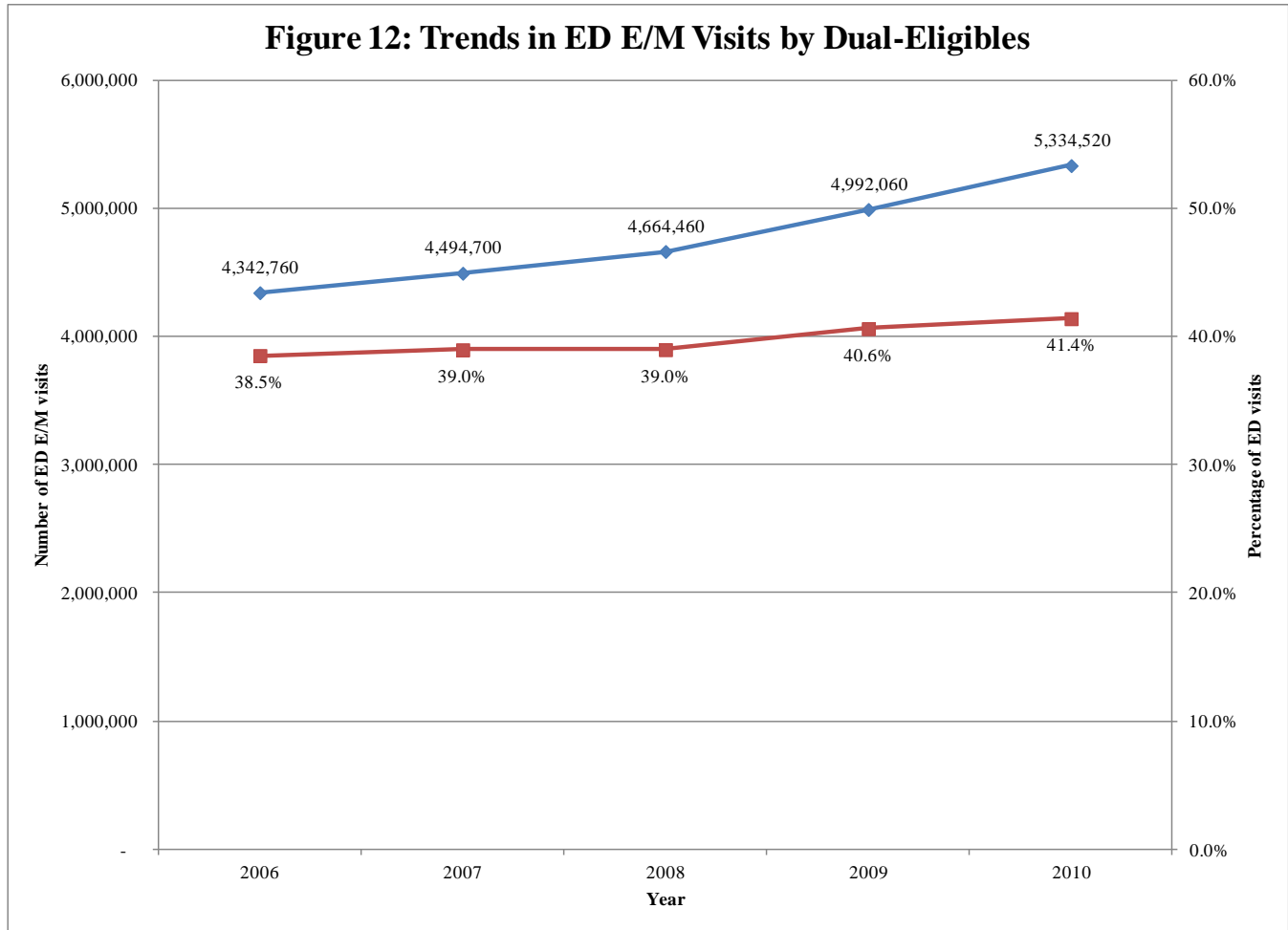
ED E/M visits in the 64 and younger age group grew faster than the average growth among all age groups.



⁶Kaiser Family Foundation, State Health Facts. Data for 2010 – 2011.
<http://www.statehealthfacts.org/comparebar.jsp?ind=294&cat=6>

Additionally, we examined trends in ED use among dual-eligibles. As can be seen in Figure 12 below, the number and percentage of ED visits by beneficiaries who are dual-eligible has been increasing, perhaps due to lack of access to other types of health care services.

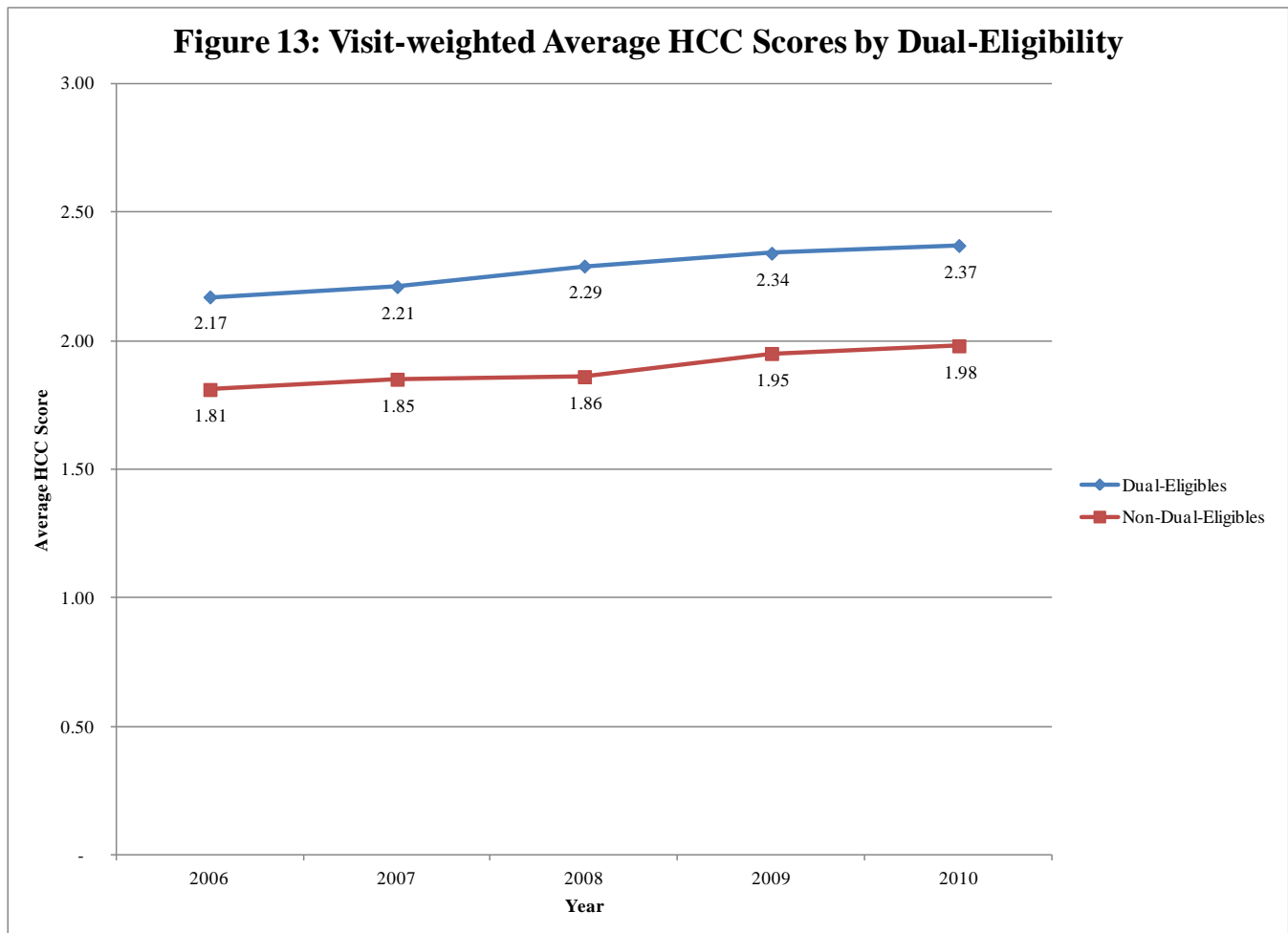
Use of the ED by those dually eligible for Medicare and Medicaid is rising.



Severity by Dual-eligibility Status

As discussed above, the types and numbers of beneficiaries seeking treatment in the ED are evolving over time. That evolution also could introduce shifts in beneficiaries' expected severity levels; sicker patients may warrant the use of the higher intensity E/M codes. As can be seen in Figure 13, severity levels differ by dual-eligibility. Dual-eligible patients have higher HCC scores as compared to those eligible only for Medicare coverage, i.e., non-duals.

Dual-eligible beneficiaries have a higher average level of severity and it is increasing.



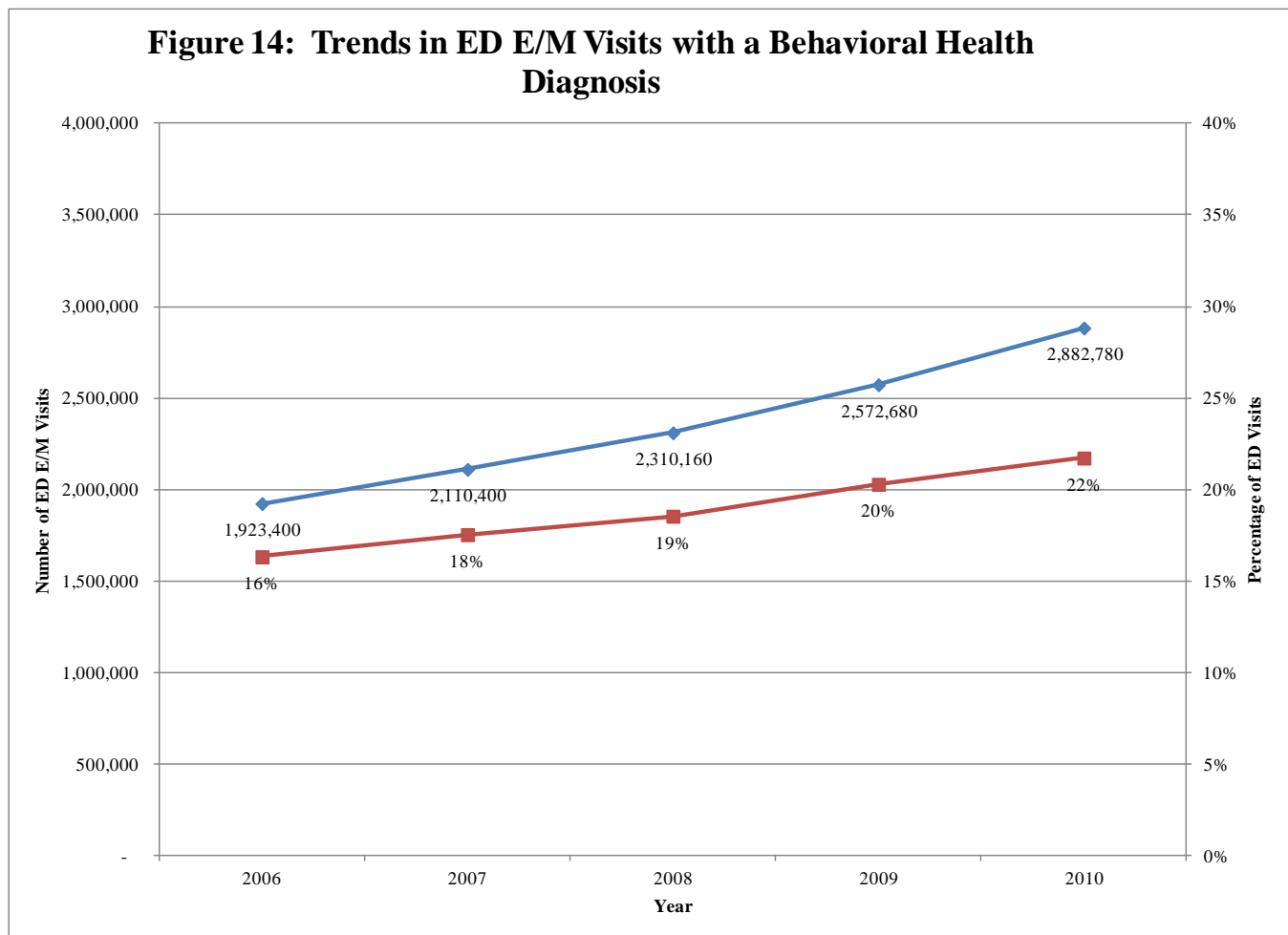
Patients with Behavioral Health Diagnoses

We also looked at trends in use and mix of E/M codes for patients with a behavioral health diagnosis because these patients can require more intensive care and often have multiple and complex health care needs. An ED E/M visit was categorized as a behavioral health-related visit if it had at least one of the following ICD-9-CM diagnosis codes:

- (i) Codes that pertained to mental, substance abuse, and neurodevelopmental disorders (290 to 319); or
- (ii) V-codes for convalescence and palliative care, following psychotherapy and other treatment for mental disorder (V66.3) or follow-up examination, following psychotherapy and other treatment for mental disorder (V67.3); or
- (ii) E-codes related to suicide and self-inflicted injury (E950 to E959).

We found that, over the study period, the number of ED visits by patients with a behavioral health diagnosis increased by close to 50 percent. These behavioral health-related ED visits rose from slightly more than 16 percent of all ED visits to about 22 percent from 2006 to 2010. See Figure 14.

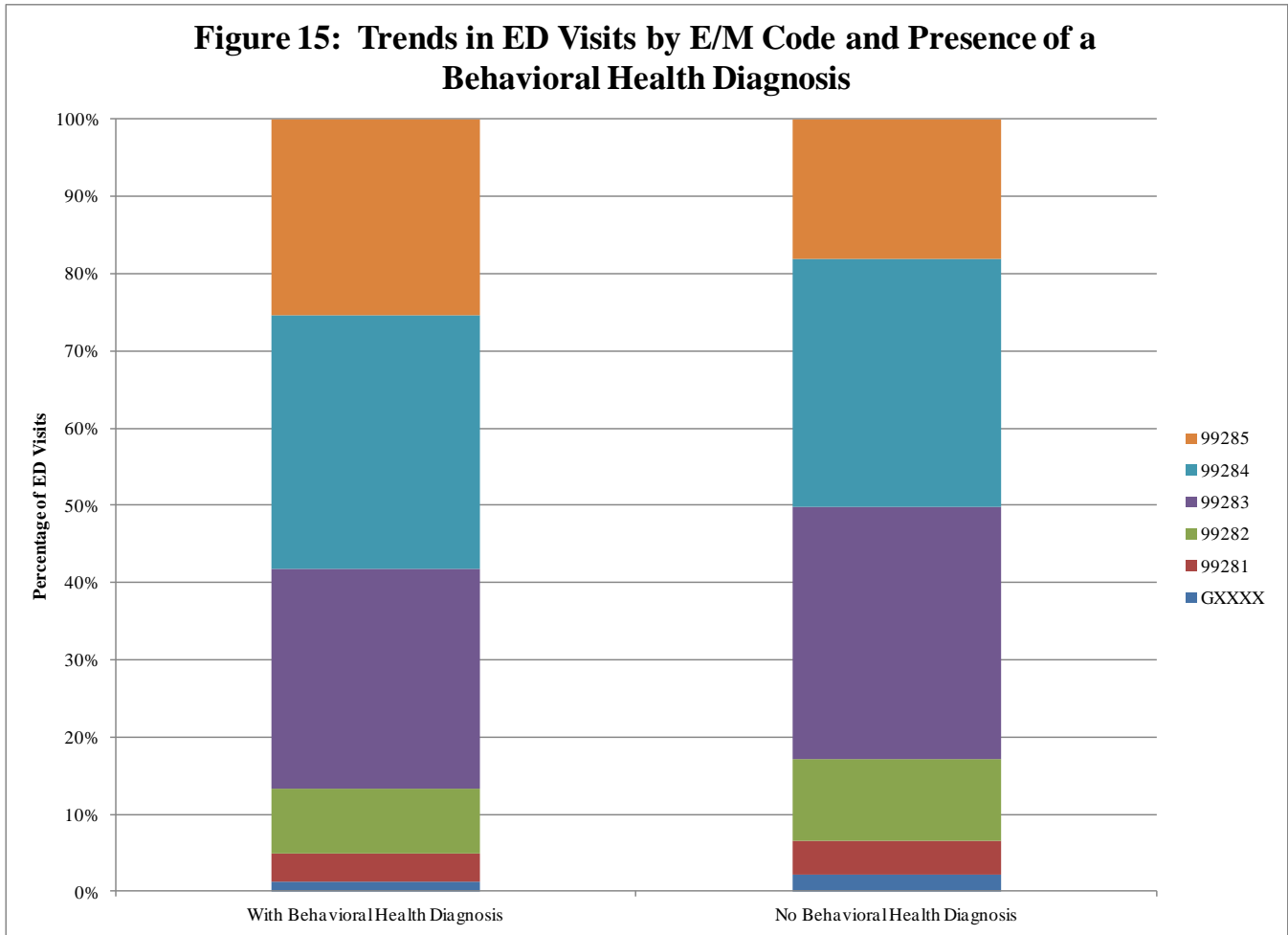
ED visits are increasing in patients with a behavioral health diagnosis.



We also found that ED visits where the patient has at least one behavioral health diagnosis have a significantly higher mix of E/M service intensity. See Figure 15.

Visits with at least one behavioral health diagnosis have a significantly higher mix of service intensity.

Figure 15: Trends in ED Visits by E/M Code and Presence of a Behavioral Health Diagnosis



Conclusion

Confirming recent reports, we found an increase in the intensity level coded for E/M visits performed in the ED over the past five years. However, our analysis suggests that the shifts in codes used reflect shifts in the patterns and characteristics of people seeking treatment. There are greater numbers of beneficiaries receiving ED E/M services, and these beneficiaries are forming a larger proportion of Medicare FFS beneficiaries over time. Beneficiaries receiving E/M services in the ED increased in severity level over the study period. The volume of ED visits with associated observation stays is increasing rapidly, and these patients have a much higher coded intensity level across all years. Beneficiaries dually eligible for both Medicare and Medicaid – a population with a higher than average severity level – comprise a larger proportion of patients receiving E/M services in the ED over our study period. Likewise, patients with a behavioral health diagnosis show growth in use of ED E/M care over time and these visits have a higher mix of service intensity. The increase in severity, greater ED use by certain populations, as well as the growth in patients with observation stays, behavioral health diagnoses and who are dually eligible, are drivers of the rising intensity of care provided to ED patients and associated visit levels coded.

Appendix A: Methodology

Data Sources

For our analysis, we used two different data sources:

1. Hospital Outpatient Prospective Payment System (HOPPS) rate-setting file; and
2. Standard Analytical File (SAF), 5 percent sample.

Hospital Outpatient Prospective Payment System (HOPPS) file

The HOPPS file contains information on all hospital outpatient paid claims for a year. For the years 2006-2010, we used the “final” file which contains claims with 180 days of claims run-out—meaning that it included claims that were paid within 180 days of the end of the rate year. However, for 2011, the final rule file was not available at the time of the analysis, and so we used the proposed file which contained information with a zero-day run-out, meaning that it only included claims paid by the end of the rate year. We expect that volumes will increase slightly with the release of the final data, but that the trends and other findings will not be significantly affected.⁷

The advantage of this dataset is that it includes payment information on 100 percent of the hospital outpatient department claims (except for Maryland which operates under a special Medicare waiver). The major drawback is that it does not allow claims to be linked, which would otherwise provide a full picture of the care a beneficiary receives across different health care settings or across a multi-year period.

Standard Analytical File (SAF), 5 percent

CMS also makes available a set of research datasets based on a 5 percent sample of Medicare beneficiaries. The advantage of this file is that it allows linking of all of the claims related to a particular beneficiary, along with demographic information. The SAF allows us to track a beneficiary’s care across health care settings. Additionally, the SAF provides beneficiary characteristics that are not available in the rate-setting files. The disadvantage of the SAF is that it is a sample of the Medicare population (although it is a large sample that has been shown repeatedly to be statistically valid and robust for national level analyses).

For our analyses, we used both sets of data. Any analysis with 2011 data included was from the HOPPS data, while any calculations limited to 2006-2010 were performed using the SAF data, because 2010 is the most recent year for which SAF data are available. For standardization, we extrapolated to the national level whenever we used the SAF data.

⁷ The final rule data were released after the analysis for this report was completed, but before the report’s final publication. Looking at the final rule data, we found that for the ED E/M codes we studied, there was an eight percent increase in volume from the 2011 proposed to 2011 final rule data.

HCC Scores

Hierarchical Condition Category (HCC) Scores were developed by CMS to risk adjust payments for potential resource utilization under the Medicare Advantage program. As such, they measure resource utilization which we have used as a proxy for severity. They are not a perfect measure, but serve as an approximation and a standard.

HCC scores are developed by examining all of the diagnoses a beneficiary has during a year, attributing a factor to each category, and then summing up all of the factors. These factors are updated each year. For consistency, we used the same year of factors across our analyses. Because some patients died, we were not able to compute HCC scores for approximately seven percent of the beneficiaries for each of the years. For these beneficiaries, we did not include them in the HCC analysis; however, we did include them in the count of ED visits and other statistics.

The HCC model software can be downloaded from:

http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk_adjustment_prior.html

Determining Behavioral Health-related Visits

Outpatient visits with a mental health-related diagnosis were identified using ICD-9-CM diagnosis codes for mental, behavioral and neurodevelopmental disorders (290-319), V-code of V66.3 (convalescence and palliative care, following psychotherapy and other treatment for mental disorder) or V67.3 (follow-up examination, following psychotherapy and other treatment for mental disorder); and E-codes related to suicide and self-inflicted injury (E950 to E959). If a claim had any of these codes it was identified as an outpatient visit with a behavioral-health related diagnosis.

Appendix B: Tables

Table 1: Average Percentage Change in Volume of ED E/M Codes, 2006-2011

	2006		2007		2008		2009		2010		2011	
	Volume of ED E&M codes	% change	Volume of ED E&M codes	% change	Volume of ED E&M codes	% change	Volume of ED E&M codes	% change	Volume of ED E&M codes	% change	Volume of ED E&M codes	% change
All HCPCS	11,270,191	-	11,473,894	1.8%	11,544,678	0.6%	11,958,396	3.6%	12,558,491	5.0%	12,810,072	2.0%

Table 2: Average Number of ED Visits per Beneficiary with an ED E/M Visit

	2006	2007	2008	2009	2010
Number of ED visits	11,779,560	12,034,300	12,458,200	12,679,840	13,270,320
Number of Beneficiaries with ED visits	6,898,000	6,933,720	6,999,780	7,105,560	7,330,800
Average number of ED visits per beneficiary	1.71	1.74	1.78	1.78	1.81

Table 3: Visit-Weighted Mean and Median Age of Beneficiaries with ED Visits (2006-2010)

	2006	2007	2008	2009	2010
Median Age - Visit Weighted	70.0	70.0	69.0	69.0	69.0
Mean Age - Visit Weighted	66.5	66.2	65.7	65.9	65.7

Data Tables for Figures 1 to 15

Figure 1: Volume of E/M Services in EDs, 2006-2011

HCPCS	2006	2007	2008	2009	2010	2011
99285	1,436,718	1,635,467	1,828,199	2,164,514	2,522,448	2,649,410
99284	3,073,629	3,283,668	3,491,829	3,848,084	4,160,480	4,371,839
99283	3,907,067	3,840,340	3,776,848	3,856,107	4,023,271	4,063,536
99282	2,166,922	1,893,584	1,701,835	1,455,377	1,274,152	1,167,739
99281	685,853	605,891	522,297	393,092	339,743	319,713
GXXXX	N/A	214,944	223,670	241,222	238,397	237,835

Figure 2: Distribution of ED Visits by E/M Code

HCPCS	2006	2007	2008	2009	2010	2011
99281-99283, GXXXX	60%	58%	55%	51%	48%	46%
99284	27%	29%	31%	33%	34%	35%
99285	13%	15%	16%	18%	20%	21%

Figure 3: ED E/M Spending over Time (in millions)

HCPCS	2006	2007	2008	2009	2010	2011
99281	\$ 50	\$ 30	\$ 27	\$ 21	\$ 19	\$ 17
99282	\$ 157	\$ 154	\$ 141	\$ 125	\$ 112	\$ 102
99283	\$ 497	\$ 492	\$ 496	\$ 524	\$ 561	\$ 564
99284	\$ 679	\$ 678	\$ 810	\$ 915	\$ 1,008	\$ 1,057
99285	\$ 315	\$ 518	\$ 693	\$ 868	\$ 1,047	\$ 1,121
GXXXX	\$ -	\$ 16	\$ 17	\$ 22	\$ 21	\$ 22

Figure 4: Total and Average Utilization of ED Services by Medicare FFS Beneficiaries

	2006	2007	2008	2009	2010
Number of beneficiaries with ED visits	6,898,000	6,933,720	6,999,780	7,105,560	7,330,800
Average number of ED visits per 1,000 FFS beneficiaries	318	327	340	345	355

Figure 5: Distribution of Beneficiaries by Number of ED Visits

	2006		2007		2008		2009		2010	
	Visits	Percentage	Visits	Percentage	Visits	Percentage	Visits	Percentage	Visits	Percentage
One ED visit	4,631,840	67.1%	4,602,820	66.4%	4,621,220	66.0%	4,629,680	65.2%	4,721,720	64.4%
Two ED visits	1,332,940	19.3%	1,349,660	19.5%	1,367,180	19.5%	1,406,780	19.8%	1,469,280	20.0%
Three or more ED visits	933,220	13.5%	981,240	14.2%	1,011,380	14.4%	1,069,100	15.0%	1,139,800	15.5%

Figure 6: Visit-Weighted Average HCC Scores for FFS Beneficiaries with ED Visits

	2006	2007	2008	2009	2010
HCC Score	1.96	2.00	2.03	2.10	2.14

Figure 7: Percentage of ED Visits With an Observation Stay

	2006		2007		2008		2009		2010	
	Visits	Percentage	Visits	Percentage	Visits	Percentage	Visits	Percentage	Visits	Percentage
ED visit with observation stay	616,200	5.2%	720,460	6.0%	798,060	6.4%	932,160	7.4%	1,061,160	8.0%
Total ED Visits	11,779,560	100.0%	12,034,300	100.0%	12,458,200	100.0%	12,679,840	100.0%	13,270,320	100.0%

Figure 8: Visit-weighted HCC Scores for ED E/M Visits With and Without an Observation Stay

Observation stays	2006	2007	2008	2009	2010
No	1.95	1.98	2.01	2.08	2.12
Yes	2.15	2.23	2.29	2.35	2.40

Figure 9: Distribution by E/M Codes for ED Visits With and Without Observations Stays

	2010	
	Without Observation Stay	With Observation Stay
GXXXX	2%	0%
99281	5%	1%
99282	11%	0%
99283	34%	4%
99284	33%	23%
99285	15%	71%

Figure 10: Distribution of ED Visits by Beneficiary Age Group

	2006	2007	2008	2009	2010
≤ 64 years	35.4%	36.3%	38.0%	37.7%	38.2%
65 to 74 years	26.6%	26.3%	25.6%	25.9%	26.0%
75 to 84 years	25.8%	24.9%	23.9%	23.4%	22.8%
≥ 85 years	12.2%	12.5%	12.5%	13.0%	13.0%

Figure 11: Cumulative Percentage Change in Number of ED Visits by Age Group (2006-2010)

Age Category	Cumulative % Change
≤ 64 years	23.3%
65 to 74 years	11.7%
75 to 84 years	0.8%
≥ 85 years	22.5%
All Ages	14.3%

Figure 12: Trends in ED E/M Visits by Dual-Eligibles

	2006	2007	2008	2009	2010
Number of Visits	4,342,760	4,494,700	4,664,460	4,992,060	5,334,520
Percentage	38.5%	39.0%	39.0%	40.6%	41.4%

Figure 13: Visit-weighted Average HCC Scores by Dual-Eligibility

	Average Visit HCC				
	2006	2007	2008	2009	2010
Dual-Eligibles	2.17	2.21	2.29	2.34	2.37
Non-Dual-Eligibles	1.81	1.85	1.86	1.95	1.98

Figure 14: Trends in ED E/M Visits with a Behavioral Health Diagnosis

	2006	2007	2008	2009	2010
Number of Visits	1,923,400	2,110,400	2,310,160	2,572,680	2,882,780
Percentage	16%	18%	19%	20%	22%

Figure 15: Trends in ED Visits by E/M Code and Presence of a Behavioral Health Diagnosis

Year	Category	HCPCS Codes											
		GXXXX		99281		99282		99283		99284		99285	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
2010	With Behavioral Health Diagnosis	35,820	1%	106,940	4%	242,160	8%	818,900	28%	947,020	33%	731,940	25%
	No Behavioral Health Diagnosis	217,800	2%	456,180	4%	1,099,640	11%	3,388,960	33%	3,349,760	32%	1,875,200	18%