

## STATISTICAL BRIEF #172

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### Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011

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#### Introduction

Health care reform has pinpointed hospital readmissions as a key area for improving care coordination and achieving potential savings.<sup>1</sup> Stakeholders are using data to devise strategies to reduce readmissions. Two criteria for evaluating potential areas of impact include volume and costs. For example, the Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Reduction Program has selected acute myocardial infarction, heart failure, and pneumonia as target areas for the Medicare population. CMS chose these conditions, in part, because of their high prevalence and their associated high costs for total admissions and readmissions among Medicare beneficiaries.<sup>2</sup> In 2015, CMS will expand their assessment of readmissions to additional conditions that represent high volume and costs.

Identifying conditions that contribute the most to the total number of readmissions and related costs for *all payers* may aid health care stakeholders in deciding which conditions to target to maximize quality improvement and cost-reduction efforts. This Statistical Brief uses readmissions data from the Healthcare Cost and Utilization Project (HCUP) to present the conditions with the largest number of 30-day all-cause readmissions among U.S. hospitals in 2011 and their associated costs. We limited the study population to Medicare beneficiaries aged 65 years and older and to individuals aged 18–64 years who were privately insured, uninsured, or covered by Medicaid. We display the 10 conditions with the largest number of readmissions for each payer.

*Readmission* was defined as a subsequent hospital admission within 30 days following an original admission (or index stay) that occurred from January through November 2011. Patients were followed across the same and different hospitals. All-cause readmissions were examined; thus, readmissions may or may not include conditions that were listed as the principal diagnosis during the index stay. Some readmissions may be planned or

#### Highlights

- In 2011, there were approximately 3.3 million adult 30-day all-cause hospital readmissions in the United States, and they were associated with about \$41.3 billion in hospital costs.
- For Medicare patients, the three conditions with the largest number of 30-day all-cause readmissions were congestive heart failure (134,500 readmissions), septicemia (92,900 readmissions), and pneumonia (88,800 readmissions). These conditions resulted in about \$4.3 billion in hospital costs.
- For Medicaid patients, the three conditions with the largest number of 30-day all-cause readmissions were mood disorders (41,600 readmissions), schizophrenia (35,800 readmissions), and diabetes (23,700 readmissions). These conditions resulted in about \$839 million in hospital costs.
- For the privately insured, the three conditions with the largest number of 30-day all-cause readmissions were maintenance chemotherapy (25,500 readmissions), mood disorders (19,600 readmissions), and complications of surgical or medical care (18,000 readmissions). These conditions resulted in about \$785 million in hospital costs.

<sup>1</sup> Orszag PR, Emanuel EJ. Health care reform and cost control. *New England Journal of Medicine*. 2010;363(7):601–3.

<sup>2</sup> Thorpe JH, Cascio T. Medicare Hospital Readmissions Reduction Program. *Legal Notes*. 2011;3(4):1–3.

<http://www.rwjf.org/content/dam/web-assets/2011/10/medicare-hospital-readmissions-reduction-program>. Accessed December 6, 2013.

unavoidable—no attempt was made to remove these types of readmissions from this descriptive analysis. Readmission rates were calculated without risk adjustment.<sup>3</sup>

## Findings

### *Overview of hospital readmissions and related costs by payer*

In 2011, there were approximately 3.3 million readmissions in the United States across all payers in the study population (Table 1). Readmissions contributed \$41.3 billion in total hospital costs.

Medicare had the largest share of total readmissions (55.9 percent) and associated costs for readmissions (58.2 percent). Medicaid had the second largest share of total readmissions (20.6 percent) and represented a lower share of associated costs (18.4 percent). Private insurance had a much smaller share of total readmissions (18.6 percent) and the second highest associated costs (19.6 percent). The uninsured represented the smallest proportion of the hospital population overall, accounting for only 4.9 percent of total readmissions and 3.7 percent of costs.

Overall, readmission rates per 100 admissions in this study population ranged from 8.7 for the privately insured to 17.2 for Medicare beneficiaries.

**Table 1. Total all-cause, 30-day readmissions and aggregate costs for the study population by payer, 2011**

Study population	Number of readmissions		Cost of readmissions		Readmission rate (per 100 admissions)
	Number of all-cause, 30-day readmissions (in thousands)	Readmissions as a percentage of total study population readmissions	Total cost of all-cause, 30-day readmissions (in millions), \$	Readmission total cost as a percentage of total cost of study population readmissions	
Medicare (65+ years)	1,800	55.9	24,000	58.2	17.2
Medicaid (18 to 64 years)	700	20.6	7,600	18.4	14.6
Privately Insured (18 to 64 years)	600	18.6	8,100	19.6	8.7
Uninsured (18 to 64 years)	200	4.9	1,500	3.7	10.6
<b>Total</b>	<b>3,300</b>	<b>100.0</b>	<b>41,300</b>	<b>100.0</b>	<b>13.8</b>

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011

<sup>3</sup> Please note that the purpose of this study was to track the total number of readmissions and associated costs; therefore, risk adjustment was not included. This approach may differ from those employed by AHRQ and CMS when readmission rates are generated for the purpose of comparison.

*Conditions that resulted in the most readmissions for Medicare patients, 2011*

Table 2 lists the 10 conditions with the most all-cause, 30-day readmissions for Medicare patients aged 65 years and older. Their rank order is based on the number of all-cause 30-day readmissions. Together, these 10 conditions accounted for 39.1 percent of all Medicare readmissions (718,100 readmissions). These conditions contributed \$9.4 billion in total hospital costs (39.0 percent of all costs for Medicare readmissions).

Three conditions currently targeted by the CMS Hospital Readmissions Reduction Program (shaded in Table 2) rank among the top 10 conditions identified here. These include congestive heart failure (134,500 readmissions; \$1.7 billion in total costs), pneumonia (88,800 readmissions; \$1.1 billion in total costs), and acute myocardial infarction (51,300 readmissions; \$693 million in total costs). The top 10 conditions include additional chronic conditions such as cardiac dysrhythmias, acute cerebrovascular disease, and chronic obstructive pulmonary disease and bronchiectasis.

Two infectious conditions also ranked among the conditions with the most readmissions. Septicemia contributed 92,900 readmissions, and urinary tract infections contributed 56,900 readmissions.

The average readmission rate for these 10 high-volume conditions among Medicare beneficiaries was 19.6 per 100 admissions. Readmission rates among these conditions ranged from 14.5 for stroke to 24.5 for congestive heart failure.

**Table 2. Ten conditions with the most all-cause, 30-day readmissions for Medicare patients (aged 65 years and older), listed by total number of readmissions in descending order, 2011**

Principal diagnosis for index hospital stay*	Number of readmissions		Cost of readmissions		Readmission rate (per 100 admissions)
	Number of all-cause, 30-day readmissions	Readmissions as a percentage of total Medicare readmissions	Total cost of all-cause, 30-day readmissions (in millions), \$	Readmission total cost as a percentage of total costs of Medicare readmissions	
Congestive heart failure; nonhypertensive	134,500	7.3	1,747	7.3	24.5
Septicemia (except in labor)	92,900	5.1	1,410	5.9	21.3
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	88,800	4.8	1,148	4.8	17.9
Chronic obstructive pulmonary disease and bronchiectasis	77,900	4.2	924	3.8	21.5
Cardiac dysrhythmias	69,400	3.8	835	3.5	16.2
Urinary tract infections	56,900	3.1	621	2.6	18.1
Acute and unspecified renal failure	53,500	2.9	683	2.8	21.8
Acute myocardial infarction	51,300	2.8	693	2.9	19.8
Complication of device; implant or graft	47,200	2.6	742	3.1	19.0
Acute cerebrovascular disease	45,800	2.5	568	2.4	14.5
<b>Total</b>	<b>718,100</b>	<b>39.1</b>	<b>9,371</b>	<b>39.0</b>	<b>19.6</b>

\* Clinical Classifications Software (CCS) label

Note: Shaded conditions are currently targeted by the CMS Hospital Readmissions Reduction Program.

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011

*Conditions that resulted in the most readmissions for Medicaid patients, 2011*

For Medicaid patients aged 18 to 64 years (Table 3), the 10 conditions with the most all-cause, 30-day readmissions accounted for 34.1 percent of all Medicaid readmissions (230,200 readmissions) and 27.1 percent of all costs for Medicaid readmissions (\$2.1 billion).

Four mental health or substance use disorders were among the conditions resulting in the most all-cause, 30-day readmissions for Medicaid patients. These conditions included mood disorders, schizophrenia and other psychotic disorders, alcohol-related disorders, and substance-related disorders. They resulted in a total of 113,100 readmissions and \$832 million in hospital costs.

Complications of pregnancy and early or threatened labor among Medicaid patients resulted in 21,500 readmissions and 19,000 readmissions, respectively.

The average readmission rate for the 10 highest volume conditions among individuals covered by Medicaid was 20.0 per 100 admissions. Readmission rates among these conditions ranged from 8.4 for other complications of pregnancy to 30.4 for congestive heart failure.

**Table 3. Ten conditions with the most all-cause, 30-day readmissions for Medicaid patients (aged 18–64 years), listed by total number of readmissions in descending order, 2011**

Principal diagnosis for index hospital stay*	Number of readmissions		Cost of readmissions		Readmission rate (per 100 admissions)
	Number of all-cause, 30-day readmissions	Readmissions as a percentage of total Medicaid readmissions	Total cost of all-cause, 30-day readmissions (in millions), \$	Readmission total cost as a percentage of total cost of Medicaid readmissions	
Mood disorders	41,600	6.2	286	3.8	19.8
Schizophrenia and other psychotic disorders	35,800	5.3	302	4.0	24.9
Diabetes mellitus with complications	23,700	3.5	251	3.3	26.6
Other complications of pregnancy	21,500	3.2	122	1.6	8.4
Alcohol-related disorders	20,500	3.0	141	1.9	26.1
Early or threatened labor	19,000	2.8	86	1.1	21.2
Congestive heart failure; nonhypertensive	18,800	2.8	273	3.6	30.4
Septicemia (except in labor)	17,600	2.6	319	4.2	23.8
Chronic obstructive pulmonary disease and bronchiectasis	16,400	2.4	178	2.3	25.2
Substance-related disorders	15,200	2.2	103	1.4	18.5
<b>Total</b>	<b>230,200</b>	<b>34.1</b>	<b>2,061</b>	<b>27.1</b>	<b>20.0</b>

\* Clinical Classifications Software (CCS) label

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011.

*Conditions that resulted in the most readmissions for privately insured patients, 2011*

For privately insured patients aged 18 to 64 (Table 4), the 10 conditions with the most all-cause, 30-day readmissions accounted for 25.0 percent of all privately insured readmissions (152,500 discharges) and 25.5 percent of costs for all privately insured readmissions (\$2.1 billion).

Readmissions for privately insured patients spanned broadly across various body systems relative to Medicare- and Medicaid-covered patients. Maintenance chemotherapy accounted for the largest share of readmissions (4.2 percent) among privately insured patients; however, it should be noted that these were most likely planned readmissions for cancer treatment. Mood disorders resulted in 19,600 readmissions (3.2 percent of privately insured readmissions).

Health care complications among the privately insured resulted in 49,700 readmissions and \$844 million in costs. These conditions included complications of surgical procedures or medical care, complications of a device or graft, and septicemia.

The average readmission rate for these 10 high-volume conditions among the privately insured was 15.9 per 100 admissions. Readmission rates among these conditions ranged from 8.7 for coronary atherosclerosis to 64.4 for maintenance chemotherapy.

**Table 4. Ten conditions with the most all-cause, 30-day readmissions for privately insured patients (aged 18–64 years), listed by total number of readmissions in descending order, 2011**

Principal diagnosis for index hospital stay*	Number of readmissions		Cost of readmissions		Readmission rate (per 100 admissions)
	Number of all-cause, 30-day readmissions	Readmissions as a percentage of total privately insured readmissions	Total cost of all-cause, 30-day readmissions (in millions), \$	Readmission total cost as a percentage of total cost of privately insured readmissions	
Maintenance chemotherapy; radiotherapy	25,500	4.2	400	5.0	64.4
Mood disorders	19,600	3.2	135	1.7	10.4
Complications of surgical procedures or medical care	18,000	3.0	250	3.1	14.2
Complication of device; implant or graft	16,900	2.8	322	4.0	15.2
Septicemia (except in labor)	14,800	2.4	272	3.4	15.4
Diabetes mellitus with complications	12,700	2.1	138	1.7	14.9
Secondary malignancies	12,000	2.0	176	2.2	24.6
Early or threatened labor	11,300	1.9	59	0.7	18.7
Pancreatic disorders (not diabetes)	11,000	1.8	156	1.9	13.8
Coronary atherosclerosis and other heart disease	10,800	1.8	154	1.9	8.7
<b>Total</b>	<b>152,500</b>	<b>25.0</b>	<b>2,062</b>	<b>25.5</b>	<b>15.9</b>

\* Clinical Classification Software (CCS) label

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011

*Conditions that resulted in the most readmissions for uninsured patients, 2011*

For uninsured patients aged 18–64 years (Table 5), the 10 conditions with the most all-cause, 30-day readmissions accounted for 35.6 percent of all uninsured readmissions (56,900 discharges) and 28.1 percent of all costs for uninsured readmissions (\$433 million).

Four conditions related to mental health or substance use disorders resulted in 28,400 readmissions and \$165 million in costs: mood disorders, alcohol-related disorders, schizophrenia and other psychotic disorders, and substance-related disorders. Three circulatory conditions—nonspecific chest pain, congestive heart failure, and acute myocardial infarction—resulted in a total of 11,100 readmissions and \$117 million in costs.

On average, the readmission rate for these 10 high-volume conditions among the uninsured was 12.1 per 100 admissions. Readmission rates among these conditions ranged from 6.5 for skin and subcutaneous tissue infections to 16.8 for congestive heart failure.

**Table 5. Ten conditions with the most all-cause, 30-day readmissions for uninsured patients (aged 18–64 years), listed by total number of readmissions in descending order, 2011**

Principal diagnosis for index hospital stay*	Number of readmissions		Cost of readmissions		Readmission rate (per 100 admissions)
	Number of all-cause, 30-day readmissions	Readmissions as a percentage of total uninsured readmissions	Total cost of all-cause, 30-day readmissions (in millions), \$	Readmission total cost as a percentage of total cost of uninsured readmissions	
Mood disorders	12,200	7.6	69	4.5	12.7
Alcohol-related disorders	8,800	5.5	52	3.4	16.0
Diabetes mellitus with complications	7,400	4.6	63	4.1	14.7
Pancreatic disorders (not diabetes)	5,800	3.6	52	3.4	15.5
Skin and subcutaneous tissue infections	4,200	2.6	35	2.3	6.5
Nonspecific chest pain	4,200	2.6	32	2.1	8.1
Schizophrenia and other psychotic disorders	4,000	2.5	25	1.6	15.4
Congestive heart failure; nonhypertensive	3,600	2.3	43	2.8	16.8
Substance-related disorders	3,400	2.1	19	1.2	10.4
Acute myocardial infarction	3,300	2.1	42	2.7	9.6
<b>Total</b>	<b>56,900</b>	<b>35.6</b>	<b>433</b>	<b>28.1</b>	<b>12.1</b>

\* Clinical Classification Software (CCS) label

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2011

## Data Source

The estimates in this Statistical Brief are based on a readmissions analysis file that was created from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID). These databases include reliable, verified synthetic patient identifiers that can be used to track a person across hospitals within a State.

For 2011, readmissions data were available from 18 States: Alaska, Arkansas, California, Florida, Georgia, Hawaii, Louisiana, Massachusetts, Mississippi, Missouri, Nebraska, New Mexico, New York, South Carolina, Tennessee, Utah, Virginia, and Washington. These 18 States are geographically dispersed and account for 46 percent of the total U.S. resident population and 45 percent of total U.S. hospitalizations. The readmissions analysis file included 14.0 million unweighted discharges.

The study population in this readmissions analysis file included discharges from community, nonrehabilitation, nonspecialty hospitals. Weights for national estimates were developed using poststratification on hospital characteristics (Census region, urban-rural location, teaching capabilities, bed size, and control/ownership) and patient age groups.

## Definitions

### *Diagnoses, ICD-9-CM, and Clinical Classifications Software (CCS)*

For the index stay, the diagnoses examined in this Statistical Brief are based on the CCS for the principal diagnosis. The *principal diagnosis* is that condition established after study to be chiefly responsible for the patient's admission to the hospital.

ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses. There are approximately 14,000 ICD-9-CM diagnosis codes.

CCS categorizes diagnosis codes into clinically meaningful categories.<sup>4</sup> This "clinical grouper" makes it easier to quickly understand patterns of diagnoses. CCS categories identified as "Other" typically are not reported; these categories include miscellaneous, otherwise unclassifiable diagnoses that may be difficult to interpret as a group.

### *Readmissions*

The 30-day readmission rate is defined as the number of admissions for each condition for which there was at least one subsequent hospital admission within 30 days, divided by the total number of admissions from January through November 2011. That is, when patients are discharged from the hospital, they are followed for 30 days in the data. If any readmission to the same or different hospital occurs during this time period, the admission is counted as a readmission. No more than one readmission is counted within the 30-day period, because the outcome measure assessed is "percentage of admissions that are readmitted." If a patient was transferred to a different hospital on the same day or was transferred within the same hospital, the two events were combined as a single stay and the second event was not counted as a readmission; that is, transfers were not considered a readmission. In the case of admissions for which there was more than one readmission in the 30-day period, the data presented in this Statistical Brief reflect the characteristics and costs of the first readmission.

Every qualifying hospital stay is counted as a separate index (starting point) admission. Thus, a single patient can be counted multiple times during the course of the January through November observation period. In addition, index admissions do not require a prior "clean period" with no hospitalizations; that is, a hospital stay may be a readmission for a prior stay and the index admission for a subsequent readmission. Admissions were disqualified from the analysis as index admissions if they could not be followed for 30 days for one of the following reasons: (1) admissions in which the patient died in the hospital, (2) admissions missing information on length of stay, and (3) admissions discharged in December 2011.

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<sup>4</sup> HCUP Clinical Classifications Software (CCS). Healthcare Cost and Utilization Project (HCUP). U.S. Agency for Healthcare Research and Quality, Rockville, MD. Updated November 2013. <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>. Accessed December 6, 2013.

### *Types of hospitals included in HCUP*

HCUP is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). HCUP data include obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care, rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals.

### *Payer (insurance status)*

Payer is the expected payer for the hospital stay. To make coding uniform across all HCUP data sources, payer combines detailed categories into more general groups:

- Medicare: includes patients covered by fee-for-service and managed care Medicare
- Medicaid: includes patients covered by fee-for-service and managed care Medicaid
- Private Insurance: includes Blue Cross, commercial carriers, and private health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
- Other: includes Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs
- Uninsured: includes an insurance status of "self-pay" and "no charge."

Encounters billed to the State Children's Health Insurance Program (SCHIP) may be classified as Medicaid, Private Insurance, or Other, depending on the structure of the State program. Because most State data do not identify SCHIP patients specifically, it is not possible to present this information separately.

For this Statistical Brief, a hierarchy was used to assign the payer category based on the primary and secondary expected payer:

- If the primary or secondary expected payer indicates Medicare, then the payer category is assigned to Medicare. This categorization includes patients who are dually eligible for Medicare and Medicaid under Medicare.
- If not Medicare and the primary or secondary expected payer indicates Medicaid, then the payer category is Medicaid.
- If not Medicare or Medicaid and the primary or secondary expected payer indicates private insurance, then the payer category is private.
- If not Medicare, Medicaid, or private and the primary expected payer indicates self-pay or no charge, then the payer category is uninsured.
- Stays for other types of payers are not reported in this Statistical Brief because this is a mixed payer group and small numbers.

For this Statistical Brief, categorization of readmission counts and costs by expected payer was based on the index stay.

### *Costs and charges*

Total hospital charges were converted to costs using HCUP Cost-to-Charge Ratios based on hospital accounting reports from the Centers for Medicare & Medicaid Services (CMS).<sup>5</sup> Costs reflect the actual expenses incurred in the production of hospital services, such as wages, supplies, and utility costs; charges represent the amount a hospital billed for the case. For each hospital, a hospital-wide cost-to-charge ratio is used. Hospital charges reflect the amount the hospital billed for the entire hospital stay and do not include professional (physician) fees. For the purposes of this Statistical Brief, costs are reported to the nearest million.

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<sup>5</sup> HCUP Cost-to-Charge Ratio Files (CCR). Healthcare Cost and Utilization Project (HCUP). 2001–2011. U.S. Agency for Healthcare Research and Quality, Rockville, MD. Updated August 2013. <http://www.hcup-us.ahrq.gov/db/state/costtocharge.jsp>. Accessed January 27, 2014.

## About HCUP

HCUP is a family of powerful health care databases, software tools, and products for advancing research. Sponsored by the Agency for Healthcare Research and Quality (AHRQ), HCUP includes the largest all-payer encounter-level collection of longitudinal health care data (inpatient, ambulatory surgery, and emergency department) in the United States, beginning in 1988. HCUP is a Federal-State-Industry Partnership that brings together the data collection efforts of many organizations—such as State data organizations, hospital associations, private data organizations, and the Federal government—to create a national information resource.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

**Alaska** State Hospital and Nursing Home Association  
**Arizona** Department of Health Services  
**Arkansas** Department of Health  
**California** Office of Statewide Health Planning and Development  
**Colorado** Hospital Association  
**Connecticut** Hospital Association  
**Florida** Agency for Health Care Administration  
**Georgia** Hospital Association  
**Hawaii** Health Information Corporation  
**Illinois** Department of Public Health  
**Indiana** Hospital Association  
**Iowa** Hospital Association  
**Kansas** Hospital Association  
**Kentucky** Cabinet for Health and Family Services  
**Louisiana** Department of Health and Hospitals  
**Maine** Health Data Organization  
**Maryland** Health Services Cost Review Commission  
**Massachusetts** Center for Health Information and Analysis  
**Michigan** Health & Hospital Association  
**Minnesota** Hospital Association  
**Mississippi** Department of Health  
**Missouri** Hospital Industry Data Institute  
**Montana** MHA - An Association of Montana Health Care Providers  
**Nebraska** Hospital Association  
**Nevada** Department of Health and Human Services  
**New Hampshire** Department of Health & Human Services  
**New Jersey** Department of Health  
**New Mexico** Department of Health  
**New York** State Department of Health  
**North Carolina** Department of Health and Human Services  
**North Dakota** (data provided by the Minnesota Hospital Association)  
**Ohio** Hospital Association  
**Oklahoma** State Department of Health  
**Oregon** Association of Hospitals and Health Systems  
**Oregon** Health Policy and Research  
**Pennsylvania** Health Care Cost Containment Council  
**Rhode Island** Department of Health  
**South Carolina** Budget & Control Board  
**South Dakota** Association of Healthcare Organizations  
**Tennessee** Hospital Association  
**Texas** Department of State Health Services  
**Utah** Department of Health  
**Vermont** Association of Hospitals and Health Systems  
**Virginia** Health Information  
**Washington** State Department of Health

**West Virginia** Health Care Authority  
**Wisconsin** Department of Health Services  
**Wyoming** Hospital Association

### About the SID

The HCUP State Inpatient Databases (SID) are hospital inpatient databases from data organizations participating in HCUP. The SID contain the universe of the inpatient discharge abstracts in the participating HCUP States, translated into a uniform format to facilitate multistate comparisons and analyses. Together, the SID encompass more than 95 of all U.S. community hospital discharges in 2010. The SID can be used to investigate questions unique to one State, to compare data from two or more States, to conduct market area variation analyses, and to identify State-specific trends in inpatient care utilization, access, charges, and outcomes.

### For More Information

For more information about HCUP, visit <http://www.hcup-us.ahrq.gov/>.

For additional HCUP statistics, visit HCUPnet, our interactive query system, at <http://hcupnet.ahrq.gov/>. HCUPnet provides ready-to-use tables on readmission rates by condition and procedure (using Clinical Classification Software categories), diagnosis related groups (DRGs), and major diagnostic categories (MDCs).

For information on other hospitalizations in the United States, refer to the following HCUP Statistical Briefs located at <http://www.hcup-us.ahrq.gov/reports/statbriefs/statbriefs.jsp>:

- Statistical Brief #166, Overview of Hospital Stays in the United States, 2011
- Statistical Brief #168, Costs for Hospital Stays in the United States, 2011
- Statistical Brief #162, Most Frequent Conditions in U.S. Hospitals, 2011
- Statistical Brief #165, Most Frequent Procedures Performed in U.S. Hospitals, 2011

### Suggested Citation

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at [hcup@ahrq.gov](mailto:hcup@ahrq.gov) or send a letter to the address below:

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