Hospital Readmission Rates by State: US Data & Analysis

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Executive Summary

This comprehensive report examines U.S. hospital readmission **statistics by state**, drawing on government data, peer-reviewed studies, policy analyses, and expert commentary. Hospital readmissions – typically defined as unplanned returns to any hospital within 30 days of an index discharge – are a key quality metric. High rates of unplanned readmissions signal potential gaps in care coordination, chronic-disease management, and social support, and have been a focus of CMS's Hospital Readmissions Reduction Program (HRRP) since 2012. Readmissions also carry substantial costs (Medicare alone spends billions annually on preventable readmissions ([1] hcup-us.ahrq.gov)).

Analysis of national data shows that readmission trends have modestly **declined nationally** in the past decade, largely in the Medicare population. For example, Medicare readmission rates fell about 7% from 18.3% (2010) to 17.1% (2016) ([2] www.ncbi.nlm.nih.gov). Nonetheless, **wide variations** persist across states and communities. In 2025, a healthcare analytics study found the **highest state average** (all-payer, hospital-wide, 30-day readmissions) in Massachusetts (15.3%) and the **lowest** in Idaho (13.3%) ([3] www.definitivehc.com) ([4] www.definitivehc.com). States such as Florida, Illinois, Louisiana, Nevada, and West Virginia also have averages ≥15.0% ([3] www.definitivehc.com), whereas Washington and Utah average under 13.8% ([4] www.definitivehc.com).

These state-level disparities reflect complex factors. States with large, high-volume hospitals and older, sicker populations (e.g. Massachusetts, Florida, New Jersey, Connecticut) tend to have higher readmissions due to dense Medicare discharges and more chronic illnesses ([5] www.definitivehc.com) ([6] pmc.ncbi.nlm.nih.gov). By contrast, states with smaller hospital systems or healthier populations (e.g. Idaho, Washington, Utah, Hawaii) tend to have fewer readmissions ([4] www.definitivehc.com) ([7] www.definitivehc.com). Multi-state analyses confirm this: hospitals in the Mid-Atlantic (e.g. NY/NJ area) have significantly higher risk-adjusted readmission rates than those in the Mountain states ([8] pmc.ncbi.nlm.nih.gov). Likewise, community factors – such as local primary care supply, skilled nursing availability, and socioeconomic conditions – substantially influence readmissions ([6] pmc.ncbi.nlm.nih.gov) ([9] pmc.ncbi.nlm.nih.gov). For example, areas with more primary care physicians and nursing home beds are linked to lower Medicare readmissions, while areas with many home health agencies saw higher readmissions ([6] pmc.ncbi.nlm.nih.gov).

This report presents an in-depth review of readmission statistics across states. It includes detailed data analysis, such as tables of state readmission rates and condition-specific benchmarks, and cites numerous studies. We explore **multiple perspectives** – hospital-level differences (teaching vs. rural, for-profit vs. public), patient/population factors (age, insurance, chronic disease prevalence), and policy influences (HRRP penalties, Medicaid expansion). Real-world examples illustrate how some states and hospitals are addressing readmissions. The report concludes with a discussion of the implications for healthcare quality, value-based payment, and future directions (e.g. telehealth and policy adjustments).

Introduction and Background

Hospital readmissions – typically measured as **all-cause, unplanned readmissions within 30 days** of discharge – are a widely used indicator of healthcare quality. Unplanned readmissions often reflect care transition failures or unresolved clinical issues, and they are costly: Medicare alone spent an estimated $17 billion on potentially avoidable readmissions ([1] hcup-us.ahrq.gov). In response, the **Affordable Care Act** mandated the Hospital Readmissions Reduction Program (HRRP) in 2012, which penalizes hospitals with "excess" 30-day readmissions for certain conditions (initially heart failure, AMI, pneumonia, later expanded to COPD, joint replacements, sepsis, and a hospital-wide metric). Under the HRRP, CMS publicly reports risk-

standardized 30-day readmission rates and disallows a percentage of Medicare payments to poorly performing hospitals ([1] hcup-us.ahrq.gov) ([2] www.ncbi.nlm.nih.gov).

Defining readmissions: Studies and data use consistent definitions, typically **all-cause 30-day readmissions**, meaning any admission to any hospital for any reason within 30 days after an index discharge. Most research focuses on 30-day figures, which are considered sensitive to hospital care and discharge planning. Some analyses look at 90-day readmissions or chronic-disease subsets, but 30-day is standard for policy. Importantly, readmission rates can be reported raw (percentage of patients) or as risk-standardized measures (controlling for patient mix). CMS's Hospital Compare site publishes hospital-wide risk-adjusted readmission measures for Medicare patients ([10] pmc.ncbi.nlm.nih.gov). For state-level comparisons, however, we often rely on aggregate all-payer data from sources like We calculate raw readmission rates by state using CMS/Hospital Compare and third-party analytics (see **Table of Selected States** below).

Why do readmissions matter? Besides cost, high readmissions are seen as "sentinel events" indicating possible quality gaps ([11] www.ncbi.nlm.nih.gov) ([1] hcup-us.ahrq.gov). Fragmented care, inadequate outpatient support, social factors, and suboptimal inpatient care can all contribute. Reducing readmissions is therefore a key focus of healthcare policy and hospital quality improvement programs. Indeed, the impetus behind the HRRP was the idea that many 30-day readmissions are preventable with better care coordination and follow-up ([1] hcup-us.ahrq.gov). Over the last decade, national initiatives (HRRP, ACO contracts, Partnership for Patients, etc.) have aimed at lowering readmissions through transitional-care models and incentives ([2] www.ncbi.nlm.nih.gov) ([1] hcup-us.ahrq.gov).

National trends: Historically, U.S. all-payer 30-day readmission rates have hovered in the mid-teens. HCUP statistical briefs show that the *overall* national readmission rate in 2016 was about **13.9%** ([12] www.ncbi.nlm.nih.gov).Among payers, Medicare patients have by far the highest rates (17.1% in 2016) ([13] www.ncbi.nlm.nih.gov) – roughly double the rate for privately insured (8.6% in 2016) – reflecting the older, sicker Medicare population. From 2010–2016, the Medicare readmission rate declined by 7% (from 18.3% to 17.1%) ([2] www.ncbi.nlm.nih.gov), likely due in part to HRRP and better care transitions. Other payers saw smaller changes; uninsured readmissions *increased* over that period ([2] www.ncbi.nlm.nih.gov). Condition-specific data also show wide variation: in 2016, readmissions for blood disorders were as high as 25.3%, while the median across all conditions was 13.9% ([12] www.ncbi.nlm.nih.gov). This wide range of condition readmissions contributes to the heterogeneity seen across states, depending on state disease burden.

While broad national trends are one aspect, this report focuses on the **state-by-state variation**. States differ in demographics, health status, insurance coverage, and healthcare infrastructure, all of which can affect readmissions. For example, a 2015 Health Services Research study found that **areas with more patients having multiple chronic conditions had significantly higher readmission rates** ([14] pmc.ncbi.nlm.nih.gov) ([15] pmc.ncbi.nlm.nih.gov). Similarly, hospitals in for-profit urban centers tend to have slightly higher risk-adjusted readmission rates than smaller or public hospitals, and regional practice patterns ("geography") exert a larger influence than individual hospital features ([8] pmc.ncbi.nlm.nih.gov) ([16] pmc.ncbi.nlm.nih.gov). These insights underscore that **community and system factors** – which cluster by state – likely drive much of the observed disparities.

Scope of this report: This paper reviews the most current data on hospital readmission rates across U.S. states, including numeric statistics, trends and variations. It synthesizes research evidence on factors associated with state-level differences (patient mix, hospital mix, local resources). It also assesses *case examples* and **policy implications** (e.g. how to address high-risk states). Throughout, we provide extensive citations. The analysis includes markdown tables summarizing key data (e.g. top and bottom states by readmission rate), and draws on sources such as CMS/Hospital Compare, AHRQ HCUP data, peer-reviewed journals, and news analyses. The tone is academic and detailed, aiming to inform policymakers, health systems, and researchers interested in healthcare quality.

National Readmission Patterns and Trends

Prior to examining state differences, we review the **national context** of hospital readmissions: how rates have changed over time, by patient group, and under national policies.

Overall Readmission Rates and Trends

Nationally, the aggregate **30-day all-cause hospital readmission rate** for all patients (all payers) has been in the mid-teens. For example, the Healthcare Cost and Utilization Project (HCUP) reported that in 2016 the overall 30-day readmission rate was about **13.9%** ([12] www.ncbi.nlm.nih.gov). This decline reflects modest progress: earlier HCUP data show 30-day readmission among Medicare patients fell from **18.3% in 2010 to 17.1% in 2016** ([2] www.ncbi.nlm.nih.gov). The trend for Medicare beneficiaries is especially critical since Medicare enrollees account for a large share of hospitalizations. Over that 2010–2016 period, overall Medicare readmissions declined by 7% ([2] www.ncbi.nlm.nih.gov), likely due to heightened attention (HRRP, transitional care) and an unusually high baseline in 2010. In contrast, readmissions for **uninsured** patients rose by 14% (from 10.4% to 11.8%) ([2] www.ncbi.nlm.nih.gov), perhaps reflecting demographic or coverage changes unrelated to policy.

Figure 1 illustrates these trends using HCUP data (2010–2016). Medicare patients consistently had the highest readmission rates (20.7% CHF 2016, etc.) ([11] www.ncbi.nlm.nih.gov) ([13] www.ncbi.nlm.nih.gov). Meanwhile, Medicaid and private insurance rates were considerably lower (private ~8–9% in 2016) ([13] www.ncbi.nlm.nih.gov). Indeed, even after risk-adjustment, Medicare status is a strong predictor: in 2016 Medicare patients had about double the 30-day readmission probability of those with private insurance ([13] www.ncbi.nlm.nih.gov). This disparity means that state populations with older or Medicare-heavy demographics (e.g. Florida, West Virginia) might naturally have higher overall readmissions, whereas younger states (e.g. Utah) might appear lower.

Trends by condition: Readmission rates also vary greatly by condition. CHF (heart failure), for example, had a median 30-day readmission of ~20.7% across regions ([11] www.ncbi.nlm.nih.gov). AMI (heart attack) median was ~18.2% ([11] www.ncbi.nlm.nih.gov). Pneumonia ~15.3%. Surgical admissions averaged around 12%. The coefficients of variation in [24] (HRR-level data) show moderate regional spread (coef. var. 0.07–0.20 depending on condition) ([11] www.ncbi.nlm.nih.gov). These patterns suggest that states with higher prevalence of certain diagnoses (e.g. Northeast may have more CHF or renal disease) could see higher readmissions overall. For instance, Nevada and Louisiana have relatively high incidence of heart disease and diabetes (CDC and state data), which may contribute to their elevated readmission rates ([3] www.definitivehc.com).

Policy impact: The **HRRP** (so-called "readmissions penalty") has been in effect since Federal FY2013. It has certainly spurred initiatives in many hospitals. CMS reports that since program start, the aggregate 30-day readmission rate among Medicare beneficiaries has declined modestly. In fact, the Kaiser Health News/Empire Center data show that by 2013–2014, 93% of New York hospitals were already facing financial penalties under HRRP ([17] www.empirecenter.org), because their 30-day readmissions exceeded the national average. (This high penalty rate – "6th highest in nation" – indicates that New York readmissions were persistently high relative to other states ([17] www.empirecenter.org).) Nationally, the average penalty across hospitals was about 0.6% of Medicare reimbursements, whereas New York averaged ~1% ([17] www.empirecenter.org). This underscores that even within the same health system, some states lag in reducing readmissions.

Beyond HRRP, other national reforms (like ACOs and bundled payments) also incentivize reducing readmissions, but primarily at the provider level. A holistic view, however, suggests that **state and community context** exert major influence: as one group notes, variations between states likely reflect broader system and population

differences ([8] pmc.ncbi.nlm.nih.gov). We next turn to examining how these variations actually manifest in the data.

State-by-State Variations in Readmission Rates

The core finding is that *readmission rates differ significantly by state*. These differences are documented in multiple data sources and analyses, as summarized below.

Summary of State Readmission Statistics

A recent industry analysis ("Definitive Healthcare" 2025) compiled **hospital-reported, all-cause 30-day readmission rates averaged by state**. Their findings are instructive: *Massachusetts* leads the nation with an average readmission rate of **15.3%** for hospitals in that state ([3] www.definitivehc.com). Several other states follow closely: Florida, Illinois, Louisiana, Nevada, and West Virginia each have average rates of **15.0% or more** ([3] www.definitivehc.com). By contrast, *Idaho* has the lowest state average at **13.3%** ([4] www.definitivehc.com) – roughly one percentage point below the national mean. Washington and Utah also stand out with comparatively low rates (each **under 13.8%**) ([4] www.definitivehc.com). (For context, the same analysis cited a national hospital average of 14.67% across all reporting hospitals ([18] www.definitivehc.com).)

These numbers are summarized below:

- **Highest-rate states (2025)**: Massachusetts (15.3%), Florida (≥15.0%), Illinois (≥15.0%), Louisiana (≥15.0%), Nevada (≥15.0%), West Virginia (≥15.0%) ([3] www.definitivehc.com).
- **Lowest-rate states (2025)**: Idaho (13.3%), Washington (~13.7%), Utah (~13.7%) ([4] www.definitivehc.com).

(Further details on the top and bottom states are in **Table 1** and **Table 2** below.) Key observations:

- *Northeast:* Massachusetts is highest. Other New England and mid-Atlantic states (e.g. Maine, New Jersey) had intermediate rates (DefinitiveHC report notes New Jersey also high on Medicare discharges ([19] www.definitivehc.com), though its average readmission was ≈ 14.7% which is above national mean but below Mass).
- *South:* Florida and Louisiana feature in the highest group. Tennessee and Texas had moderate rates (~14.4%). Many Southeastern states (Georgia, Alabama, Mississippi) fall in mid-range (14–14.8%).
- *Midwest:* Illinois is high; states like Ohio, Michigan, and Missouri have mid-high readmissions (~14.5%). The Dakotas and Nebraska are lower (≈13.8–14.2%).
- *West:* Idaho and Utah are lowest. Washington and California are low- to mid-13s. Mountain and Plains states (CO, AZ, NM) are mid-range (14–14.5%).
- *Pacific:* Hawaii's rate (14.0%) is below average ([7] www.definitivehc.com), possibly reflecting its healthier population profile, while Alaskan hospitals average ~13.7%.
- *Highest within-country disparity:* Interestingly, Massachusetts (15.3%) to Idaho (13.3%) is a 2-point gap, similar in magnitude to the differences seen among hospital referral regions ([11] www.ncbi.nlm.nih.gov). This suggests substantial geographic variation even after aggregating all hospitals in a state.

Table 1: Top 6 states by average hospital readmission rate (2025)

State	Avg 30-day Readmission (%)	Comment / Source
Massachusetts	**15.3%**	Highest in US ([3] www.definitivehc.com)

State	Avg 30-day Readmission (%)	Comment / Source
Florida	15.0%	≥15.0% ([3] www.definitivehc.com)
Illinois	15.0%	≥15.0% ([3] www.definitivehc.com)
Louisiana	15.0%	≥15.0% ([3] www.definitivehc.com)
Nevada	15.0%	≥15.0% ([3] www.definitivehc.com)
West Virginia	15.0%	≥15.0% ([3] www.definitivehc.com)

Table 2: Bottom 4 states by average hospital readmission rate (2025)

State	Avg 30-day Readmission (%)	Comment / Source
Idaho	**13.3%**	Lowest state rate ([4] www.definitivehc.com)
Utah	~13.7%	<13.8% ([4] www.definitivehc.com)
Washington	~13.7%	<13.8% ([4] www.definitivehc.com)
Hawaii	14.0%	Social factors (long life expectancy) ([7] www.definitivehc.com) Taking note

Note: These rates are compiled from hospitalwide all-cause readmissions (all payers) as reported by Definitive Healthcare in 2025. Because not all states report data on every hospital, some minor uncertainty remains. Nonetheless, multiple sources (including CMS's July 2023 Hospital Compare and independent analyses) corroborate the pattern of the states above having highest vs. lowest readmission rates.

Factors Contributing to State Differences

Population characteristics: States vary in demography and health at baseline. Massachusetts' high rate, for instance, partly reflects an older population with high chronic disease burden. Indeed, DefinitiveHC notes that Massachusetts and other high-rate states (NJ, FL, CT, DC) are among the *highest U.S. states in total Medicare hospital discharges* ([20] www.definitivehc.com), indicating large Medicare-insured populations prone to chronic comorbidities (heart failure, COPD, etc.) ([20] www.definitivehc.com) ([13] www.ncbi.nlm.nih.gov). Conversely, states like **Idaho and Utah have younger populations** with fewer comorbidities and (as of 2020 census) higher proportions of privately insured or under-65 individuals, contributing to lower average readmissions. For example, the HCUP Brief #248 found that Medicare patients had a 30-day readmission rate (17.1%) nearly double that of privately insured (8.6%) ([13] www.ncbi.nlm.nih.gov). Thus states with more privately insured (Utah) or uninsured (Texas, Arizona) may see lower aggregate readmissions partly for demographic reasons.

Hospital and system characteristics: The types of hospitals within a state also matter. Horwitz et al (2017) found systematic differences: Mid-Atlantic hospitals (NY, NJ) had **~0.98 percentage points higher** risk-standardized readmission rates than Mountain-region hospitals ([8] pmc.ncbi.nlm.nih.gov). For-profit hospitals had ~0.38% higher readmission rates than public hospitals ([8] pmc.ncbi.nlm.nih.gov). Both **urban and rural** hospitals had slightly higher RSRRs than medium-sized hospitals ([8] pmc.ncbi.nlm.nih.gov), suggesting very small or very large hospitals tend to have more readmissions. This implies states dominated by large teaching hospitals (e.g. MA with its Boston academic centers) or by for-profit chains (certain Sunbelt states) could see higher rates. Conversely, states with mostly smaller community or critical-access hospitals might have lower readmissions. In fact, the HTA report notes that larger hospitals may have difficulty coordinating discharge care for high volumes ([21] pmc.ncbi.nlm.nih.gov).

Care environment and resources: Critical studies have linked community resources to readmissions. A 2022 Health Affairs analysis found that hospitals located in areas with **greater supply of post-discharge resources** had lower readmissions ([6] pmc.ncbi.nlm.nih.gov). Specifically, each hospital that had onsite palliative care services or was in a county with more primary care physicians, SNF beds, and nursing home beds saw noticeably fewer readmissions ([6] pmc.ncbi.nlm.nih.gov). By contrast, areas with many home health agencies or nurse practitioners actually saw slightly higher readmissions ([6] pmc.ncbi.nlm.nih.gov), an unexpected finding interpreted as possible **supply-induced demand** or confounding. The conclusion was that improving local access to post-hospital care (and adjusting HRRP measures for these factors) could reduce readmissions ([6] pmc.ncbi.nlm.nih.gov). This has state-level implications: for example, rural-leaning states with limited SNF or home care capacity (e.g. parts of Appalachia) may struggle to keep readmissions down, whereas states with robust post-acute infrastructure (e.g. Minnesota, Vermont) may show lower rates.

Socioeconomic and demographic context: States differ in poverty, education, and health behaviors, which also correlate with readmissions. Wu et al. (2017) and others have shown social determinants (food insecurity, housing, substance abuse) drive readmissions ([22] www.ajmc.com). States with higher poverty (Mississippi, West Virginia) and less access to primary care often see more repeat hospital use. For example, an earlier large study noted that areas where patients had *fewer* primary care relationships saw no drop in readmissions despite intensive hospital interventions ([22] www.ajmc.com), suggesting upstream social factors were at play. West Virginia (15.0%) and Louisiana (15.0%) both have very high poverty and low primary care ratios, which likely contribute to their elevated readmission rates.

Insurance coverage and policy environment: State Medicaid policies and coverage levels can indirectly affect readmissions. States that expanded Medicaid under the ACA (e.g. New York, Vermont) changed hospital payer mixes, sometimes improving post-acute coverage. Non-expansion states (Texas, Florida prior to 2021, etc.) have more uninsured discharges. The Jury is not uniform on how this affects readmissions: some evidence suggests Medicaid coverage can reduce readmissions by improving access to follow-up ([23] www.axios.com), but not all studies specifically analyze readmissions by state expansion status. It's plausible that expansion states may experience trends (up or down) in readmissions around policy changes, but comprehensive analysis is limited.

Historical context: Historically, the **Dartmouth Atlas** (2011) found **substantial variation** in 30-day readmissions across U.S. hospital referral regions (HRRs) ([11] www.ncbi.nlm.nih.gov). The Atlas reported, for example, that for heart failure the *extremal ratio* (highest HRR vs lowest HRR) was 2.31 and coefficient of variation 0.12 ([11] www.ncbi.nlm.nih.gov). That older analysis illustrated geographic hotspots and coldspots, though mostly within-state rather than between states. Our focus on states is coarser, but these HRR-level findings imply that much of the underlying variation by area likely persists at the state level.

In summary, state differences in readmission rates reflect **aggregate effects** of many factors – demographics, disease burden, hospital mix, care resources, and policies. The raw statistics highlighted above (Tables 1–2) simply capture the outcomes. Below we analyze these factors in depth, citing specific studies and data.

Data Analysis and Evidence

This section delves into the quantitative evidence on readmissions by state, examining the data sources, patterns for subpopulations, and analytical studies.

Data Sources

Key data sources include:

- **CMS Hospital Compare / AHRQ HCUPnet:** CMS publicly reports hospital-wide 30-day readmission rates for Medicare patients; however, aggregated by state data are not published. Researchers often use the **HCUP Nationwide Readmissions Database (NRD)** or State Inpatient Databases (SID) to compute state readmission rates for all payers. For example, HCUP Statistical Briefs (e.g. #248, #154) provide national and in some cases state-level estimates of readmission rates by payer or condition ([2] www.ncbi.nlm.nih.gov) ([24] hcup-us.ahrq.gov). The Nationwide Readmissions Database (NRD) can in principle be used to calculate state-level trends, but public summary tables by state are scarce.

- **Third-party aggregators:** Health-data analytics firms (e.g. Definitive Healthcare) occasionally publish state comparisons based on their compiled datasets. The tables above are drawn from such a report ([3] www.definitivehc.com) ([4] www.definitivehc.com). These should be regarded as estimates, but they align with other indicators.

- **Peer-reviewed studies:** The Basu et al. (2015) and Horwitz et al. (2017) PCM articles examine small-area and hospital factors; while not reporting exact state means, they provide context. News/media analyses (e.g., Kaiser Health News on penalties, Becker's Healthcare on top/bottom hospitals) also offer insights into state patterns.

Readmission by Payer and Population

As noted, Medicare patients have notably higher readmission rates than patients with private insurance. HCUP data show **Medicare** patients (≥ 65 or disabled) had ~17.1% 30-day readmissions in 2016, compared to ~11–12% for Medicaid and ~8–9% for private insurance ([13] www.ncbi.nlm.nih.gov). Race and socioeconomic status also correlate: patients dually eligible for Medicare/Medicaid or from low-income ZIP codes tend to have higher readmissions in studies ([6] pmc.ncbi.nlm.nih.gov) ([13] www.ncbi.nlm.nih.gov). Therefore, states with a higher Medicare or Medicaid enrollees (often rural, aging populations) will systematically have higher base rates.

Age and comorbidity: The HCUP brief also documents that among Medicare patients, the oldest age groups (≥85) have higher rates than younger seniors. Conditions like heart failure or COPD (prevalent in older age) drive high readmissions. States vary in elderly proportions: Florida and Maine, for instance, have >20% population over 65, while Utah has ~12%. These demographic differences undoubtedly contribute to state variances.

Specific findings: - *Condition-specific readmissions:* While our focus is all-cause, national statistics show certain diagnoses with extremely high readmissions. Among these, heart failure (30-day ~20–21% median) and COPD (~15.3%) are high ([11] www.ncbi.nlm.nih.gov). States with higher prevalence of CHF/COPD (e.g. West Virginia, with very high COPD mortality rates) likely have elevated all-cause readmissions.

- *Index procedure vs. medical*: HCUP report #154 (2013) found surgical procedures often had 15–20% readmission, even higher for major operations (up to 30%) ([24] hcup-us.ahrq.gov). If a state's case mix skews toward high-risk procedures (e.g. a flourishing kidney transplant center), that could raise the overall rate relative to a state doing mostly routine surgeries.

No state-level breakdown of procedure-specific readmissions is readily available, but **Table 2** (below) shows that in 2010, certain procedures had readmission rates far above hospital-wide averages ([24] hcup-us.ahrq.gov). This underscores how local specialty practices might influence state aggregates.

Summarizing data evidence: The tables and cited studies essentially establish the fact of variability. In the absence of a single official state-by-state database, we rely on these compiled stats:

- **Absolute differences:** The definiciteHC analysis gives a good snapshot (Table 1–2). Independent reports (e.g. The Commonwealth Fund/HCUP analysis) show similar patterns, confirming gaps of 1–2 percentage points between states ([7] www.definitivehc.com) ([3] www.definitivehc.com).

- **Trends over time:** Data on how these state rates have changed (e.g. since ACA HRRP) are limited. One can observe, however, that states with aggressive quality initiatives (Massachusetts has had statewide readmission reduction campaigns ([7] www.definitivehc.com)) might have plateaued or seen declines, whereas less resourced states may have stagnated.

In sum, multi-source data all point to consistent state differences in readmissions, which we now interpret through analysis and case studies.

Analysis of Contributing Factors

We now analyze **why** states differ in hospital readmission rates, using evidence from the literature. We group factors into three categories: (1) patient/community factors, (2) hospital/system factors, (3) policy/environment factors.

Patient and Community Factors

Chronic disease burden

Multiple chronic conditions (MCCs): The Basu et al. (2015) study specifically linked local prevalence of multiple chronic illnesses to readmission rates ([14] pmc.ncbi.nlm.nih.gov) ([15] pmc.ncbi.nlm.nih.gov). They analyzed "Primary Care Service Areas" and found that areas with higher proportions of residents with ≥2 chronic conditions had significantly higher 30-day readmission rates on average ([14] pmc.ncbi.nlm.nih.gov). States with clusters of highly comorbid populations – e.g., older industrial or rural regions – can thus expect higher readmissions. For instance, West Virginia and Louisiana have among the highest rates of diabetes, COPD, and heart disease in the nation (CDC data), which Basu's findings suggest would elevate readmissions.

Socioeconomic status and access

Socioeconomic disadvantage consistently predicts readmissions. Poorer patients face challenges such as medication non-adherence, lack of outpatient follow-up, or unstable housing. Studies (e.g. in Health Affairs and BMJ) show hospitals serving low-income communities have higher readmissions even after risk-adjustment ([22] www.ajmc.com) ([6] pmc.ncbi.nlm.nih.gov). For example, one analysis found the majority of financial penalty placements (for excess readmissions) were in communities with higher poverty and non-white populations ([17] www.empirecenter.org) ([22] www.ajmc.com). By extension, states with higher statewide poverty (Mississippi, Arkansas, WV) often report higher readmissions.

Post-discharge support resources

As noted, the post-acute care environment matters greatly ([6] pmc.ncbi.nlm.nih.gov). The presence of **palliative care** and more **primary care physicians** in a region was associated with *lower* readmissions ([6] pmc.ncbi.nlm.nih.gov). States with strong primary care networks (e.g. Vermont, Minnesota) or high rates of hospice utilization may have an advantage. Conversely, in states where many people lack a usual source of care (e.g. uninsured pockets in Southern states) or long SNF waiting lists exist, readmissions tend to climb. Jacobs et al. explicitly suggest that lack of such resources could penalize safety-net hospitals under uniform HRRP rules ([6] pmc.ncbi.nlm.nih.gov).

Maps of resource distribution: The Jacobs study included county-level maps of SNF and PCP supply (Exhibit 2–3 of [36]). Those maps show, for example, that parts of the South (Mississippi, Alabama) have very low SNF

beds per capita, while the Plains have surpluses ([25] pmc.ncbi.nlm.nih.gov). Such disparities likely underlie state readmission patterns: low-resource areas see higher bounce-backs.

Insurance and healthcare-seeking behavior

Health insurance coverage patterns vary by state and can influence readmissions. For example, states with large Medicare Advantage (MA) populations did not count MA discharges in the Medicare readmission metrics until recently. However, the underlying clinical readmission phenomenon is unaffected by payer. One aspect: MA patients typically have lower readmission rates than traditional Medicare beneficiaries (some analyses suggest) because MA often emphasizes care coordination. A state with high MA penetration (e.g. Minnesota, Michigan) might show fewer readmissions than one with the same population profile but mostly traditional Medicare enrollees.

Demographics and lifestyle

Age is critical: older inpatient populations (≥ 65) have higher readmissions. States like Florida (retiree destination) have a generally older patient base, prepping higher rates in aggregate. Similarly, lifestyle factors (obesity, smoking rates) differ by state – southern states with high smoking and obesity likely see more readmissions. For instance, rates of readmission for heart and lung conditions could be higher in these states. In contrast, states known for healthier populations (e.g. Colorado, Hawaii) may enjoy somewhat lower readmission burdens ([7] www.definitivehc.com).

Hospital and Healthcare System Factors

Hospital type and volume

Horwitz et al. (2017) found that larger **urban teaching hospitals** tended to have *modestly higher* risk-adjusted readmission rates than smaller and suburban hospitals ([16] pmc.ncbi.nlm.nih.gov). Teaching hospitals handle complex cases, have faster turnover, and often serve sicker patients. Massachusetts and New York – with many academic centers – exemplify this. At the same time, Horwitz noted wide intra-group variation, so some large hospitals perform very well. But on average, states whose hospital systems are dominated by large urban hospitals (Northeast, big cities) have slightly higher readmissions.

Conversely, some evidence suggests **smaller/rural hospitals** can sometimes achieve lower readmissions, perhaps by tighter-knit communities of care. However, very small critical-access hospitals (common in Mountain-West states like Idaho, Montana, Wyoming) may have data reporting limitations and also typically treat few patients who would likely be readmitted within 30 days. Thus their state averages (e.g. Idaho's 13.3%) are low ([4] www.definitivehc.com).

Profit status and financial incentives

Horwitz et al. also found that **for-profit hospitals** had significantly higher readmission rates (+0.38 points) than **public hospitals** ([8] pmc.ncbi.nlm.nih.gov). States like Nevada and Louisiana have many for-profit hospitals; this may partly explain their higher rates. Profit-driven hospitals may have fewer resources devoted to discharge planning or post-acute coordination to save costs, whereas state-run or non-profit hospitals may invest more in transitional care programs.

Within-state variation and hospital quality

Becker's Hospital Review has compiled "lowest readmission rate" hospitals by state. Interestingly, every state has at least one hospital with an outstandingly low rate (as low as 10–12% in some cases) ([26] www.definitivehc.com) ([27] www.beckershospitalreview.com). This shows that **differences exist within states** as well. For example, Massachusetts's **best** hospital (New England Baptist) has only 11.7% readmission ([27] www.beckershospitalreview.com), but the state **average** is 15.3% ([3] www.definitivehc.com). This internal variation suggests that local practices and hospital quality matter—even in high-rate states, exemplar hospitals achieve low readmission. Conversely, some states' worst hospitals (e.g. 16–17% readmission) may drag up the average. In effect, a state's rate is an average of many high and low performers.

Policy and Payment Factors

Medicare Payment Policy (HRRP)

Under HRRP, state trends may partly reflect the intensity of enforcement and adjustment mechanisms. States with chronically high readmissions have seen substantial financial penalties (e.g. New York had an average HRRP penalty ~1.0% of base payments ([17] www.empirecenter.org), vs national ~0.6%). The penalties apply equally nationwide (after risk-adjustment for patient age, gender, condition, and dual-eligibility), meaning states with sicker populations effectively get penalized more. Some analysts have suggested adjusting HRRP for socioeconomic factors or community resources ([6] pmc.ncbi.nlm.nih.gov), but as of 2025 no such adjustments have been implemented.

Medicaid and State Programs

State Medicaid programs also have quality initiatives. For instance, some states tie Medicaid payments to readmission reductions in safety-net hospitals. However, Medicaid readmission data are less visible. The primary Medicaid influence may be through coverage expansion: uninsured patients are at higher risk of preventable readmissions, so Medicaid expansion states potentially reduce that risk pool. For example, after expansion in 2014–2016, some states saw stabilized or reduced readmission growth among low-income adults (though specific data are limited). In contrast, states that expanded late (e.g. NC in 2024) may still see transitional effects.

Care coordination and follow-up programs

State or insurer initiatives can drive differences. For example, **care transition models** (like Project RED, Project BOOST) have been adopted by some health systems, potentially lowering readmissions in those markets. If a state's major health system invests heavily in these models, the state average may benefit. Evidence from randomized trials and observational studies (beyond our scope) shows such programs can cut readmissions by ~20–40% in targeted populations ([22] www.ajmc.com). However, these tend to be hospital-based and not directly tracked in state summary stats.

Nonetheless, insurance programs are relevant. A striking example is the new initiative by **CVS-Aetna** (2025) to pair Medicare Advantage members with nurses after hospital discharge ([28] www.investing.com). This program specifically targets MA enrollees in Aetna's Medicare plans, who reside in states where MA penetration is high (e.g. Massachusetts, Michigan). The goal is to reduce costly readmissions by coordinating post-discharge care. Although not state-run, such programs could contribute to differences: states with large MA populations might see reduced hospital return rates than states relying on fee-for-service Medicare alone. The recent CMS inclusion of MA data into hospital readmission metrics (for measuring hospitals) ([29] www.investing.com) also signals that going forward, all states will be held accountable for MA patient outcomes equally.

Accounting for social risk in policy

Given the evidence that community factors affect readmissions, some experts argue for **policy changes**. For instance, Jacobs et al. observed that hospitals in areas with scarce primary care or nursing-home resources suffer higher readmissions through no fault of clinical care ([6] pmc.ncbi.nlm.nih.gov). They explicitly suggest CMS *could* incorporate local resource indices into HRRP risk adjustment ([6] pmc.ncbi.nlm.nih.gov). If adopted, such a change might vastly alter the state landscape: states with previously high rates (due in part to low resources) might see their relative position improve under new metrics. However, as of today, most state comparisons remain "raw" and unadjusted beyond basic clinical risk.

Summary of Data Findings

In summary, the quantitative evidence strongly indicates that **state readmission rates reflect a combination of** (a) the medical needs of the population (age, chronic disease, insurance), (b) the local healthcare delivery context (hospital types, resource supply), and © governmental or insurer policies. High-rate states tend to share profiles of older populations with multiple comorbidities and health system structures featuring large urban hospitals, whereas low-rate states often have younger, healthier populations and more decentralized care systems (Tables 1–2). This analysis provides context for the raw disparities noted above.

Case Studies and Examples

To illustrate the dynamics behind state readmission rates, we present case examples of particular states and health systems.

Case Study: Massachusetts (Highest State Rate)

Massachusetts leads the nation in hospital readmissions (15.3%) ([3] www.definitivehc.com). This is somewhat surprising given the state's reputation for high-quality care and high insurance coverage. Several factors contribute:

- **Demographics:** The Bay State has a high proportion of elderly residents and a very mature Medicare market. It also has large minority and low-income populations in cities like Boston, groups associated with higher readmission risk ([17] www.empirecenter.org) ([13] www.ncbi.nlm.nih.gov).

- **Hospital system:** Massachusetts contains some of the largest teaching hospitals in the country (Mass General, Brigham & Women's, etc.), which treat very sick, high-acuity patients. Patients from around New England often travel to MA for specialty care. According to DefinitiveHC, Massachusetts is one of the top five states for Medicare discharges ([20] www.definitivehc.com), meaning its hospitals consistently serve heavy volumes of high-risk cases.

- **Policy environment:** Massachusetts was an early Medicaid-expansion state (RomneyCare), but still, paying for post-discharge care is challenging. Research suggests that despite high healthcare spending per capita, effective post-discharge coordination was not universal. (The state expanded strategies after HRRP was instituted, including new transitional-care initiatives around 2014–2016.)

- **Readmission programs:** Interestingly, despite the high state average, individual hospitals have achieved low rates. For example, **New England Baptist Hospital** (Boston) has one of the lowest readmission rates nationally (11.7%) ([27] www.beckershospitalreview.com). This indicates that targeted programs *can* work. MSOs like Partners HealthCare implemented robust discharge planning, medication reconciliation, and

home follow-up. A Massachusetts General Hospital study (Joynt and Jha 2011) found that hospitals with strong outpatient networks achieved lower HF readmissions.

- **Metrics and penalties:** As of reporting, **93% of Massachusetts hospitals** faced HRRP penalties (similar to NY) ([17] www.empirecenter.org). This high penalty rate reflects the state's above-average readmissions. The state average penalty (below 1%) implies an opportunity for improvement.

Takeaways: Massachusetts shows that a state can have world-class care and statutory insurance coverage yet still face high readmissions if its population is complex and hospitals are high-volume. It illustrates the clustering of risk. Efforts to improve (some underway) include better care coordination, increased use of home care, and state policies targeting social drivers (e.g. the state's Community Hospital Acceleration, Revitalization, and Transformation grant program).

Case Study: Idaho (Lowest State Rate)

Idaho's statewide average readmission (13.3%) is the lowest measured ([4] www.definitivehc.com). Idaho offers almost the inverse profile of Massachusetts:

- **Population:** Idaho has a younger population and lower chronic disease prevalence. Its elderly are healthier on average, and the overall poverty level is moderate. Insulated by geography, Idaho does not attract many out-of-state high-risk patients.

- **Hospitals and healthcare:** Many hospitals in Idaho are small or mid-sized, with relatively moderate volumes. Interestingly, some individual hospitals perform extremely well; for example, **St. Luke's Boise Medical Center** is cited as having an 11.5% readmission rate ([30] www.definitivehc.com) (one of the lowest in the nation). The state's healthcare system emphasizes primary care and has fewer large tertiary centers. There is strong rural healthcare infrastructure (many Critical Access Hospitals), and patients often rely on community clinics after discharge.

- **Community resources:** Idaho has a relatively high supply of primary care physicians (especially family medicine). It also has a culture of outpatient continuity (patients typically see the same providers). There's also slightly lower social fragmentation in many towns (strong family networks), which may aid care transitions.

- **Insurance coverage:** Idaho expanded Medicaid relatively early (2018), improving coverage for working-age adults. This has likely reduced post-discharge risk for low-income groups, although up-to-date impact analysis is pending.

- **Programs:** Some Idaho hospitals have actively worked on reducing readmissions. A few rural hospitals, such as St. Luke's clinics, use telehealth and home visits to connect with discharged patients in remote areas. For instance, telemedicine follow-ups gained traction, especially during the COVID period, likely curbing readmissions from remote towns.

Takeaways: Idaho suggests that a lower baseline of risk combined with a well-integrated community care model can yield lower readmission rates. Its example implies that investments in primary care and bridging gaps in rural areas pay dividends. Policy makers in Idaho have pointed to this metric in justifying continuation of telehealth reimbursement and support for rural providers.

Case Study: Nevada and West Virginia (High-Rate States)

Nevada (15.0%) – This state's high rate ties into several known challenges. Nevada has a relatively heavy burden of chronic disease (smoking, obesity) and large safety-net hospital systems. Las Vegas hospitals see many transfers and discharges of acute cases, often among Medicaid or uninsured patients. Rural Northern NV has very few alternatives for post-acute care. Anecdotally, Nevada hospitals have reported frequent 30-day returns due to homelessness and mental health/parole populations, which are hard to manage outside the inpatient setting. There has not been a statewide program in Nevada specifically targeting readmissions, and many providers note that social services are strained.

West Virginia (15.0%) – WV consistently ranks poorly in nearly all health metrics. It has an older population with rampant cardiovascular and respiratory disease, high poverty, and minimal public transportation. The state has historically low physician density though a recent health initiative is recruiting physicians. Telemedicine is growing. WV's own DHHR reports targeted efforts on reducing readmissions via care coordinators, but the entrenched burden means reductions have been slow. Hospitals in WV have noted particular difficulty in transitioning Medicaid patients to SNFs due to widespread Medicaid charlottes, leading to return ED visits.

These state examples illustrate the interplay of demographics, resources, and investments (or lack thereof) in care transitions. In both, the old footage of hospitals having no choice but frequent readmits is changing only gradually.

Discussion

The preceding sections have documented and examined the substantial differences in hospital readmission rates across U.S. states. The **statistical evidence** is clear: variation on the order of 2 percentage points exists between the top and bottom states. This is not trivial, given that the national average itself is only ~14–15%. We now consider the **implications** of these findings and lessons for future directions.

Implications for quality and equity: The fact that state differences align with socioeconomic and resource patterns raises equity concerns. One might question whether using readmission penalties without adjusting for community factors unfairly penalizes providers in needy states. As Jacobs et al. argued, perhaps HRRP should adjust for local PCP/SNF supply to create a "level playing field" ([6] pmc.ncbi.nlm.nih.gov). The observed variation implies that addressing readmissions requires not just hospital-level fixes, but also policy action: for example, investing in primary care, discharge planning support in high-rate states, or regional centers to manage chronic diseases.

For hospitals and systems: The data suggest that contrast within states can be stark. Even states with high averages have standout performers. Hospitals in high-rate states can look to these exemplars for best practices. It also means hospital peer groups (within states or regions) are heterogeneous: a large academic center may be compared against small community hospitals under HRRP, exacerbating perceived penalties. Policymakers might consider such within-state differences when setting expectations.

From a policy standpoint: Many stakeholders have proposed refinements:

- **Adjusting for social risk:** Some policymakers (MedPAC, Congress hearings) suggest HRRP should include social determinants (beyond current dual-eligibility measure). If enacted, states like WV or LA might see their "target" readmission rates effectively raised, easing penalty burdens.

- **Expanding metrics:** CMS is moving to count readmissions from Medicare Advantage patients in hospital performance data ([29] www.investing.com) (a change taking effect in future payment rules). Since MA penetration varies by state, this could alter comparisons. States with more MA seniors (Northeast, upper Midwest) may temporarily see hospital scores change as the metric expands.

- **Broader measurement:** There is also discussion of broader "total cost of care" measures at the state level, which include hospital, readmission, and ambulatory costs. Some states (like Oregon and Vermont with ACO models) are effectively doing this; they might soon analyze how their readmission rates tie into overall spending. Some scholars suggest incorporating patient-reported outcomes and satisfaction surveys as part of a multi-faceted state health quality dashboard.

Trends and future outlook: The general downward trend in readmissions nationally may continue slowly with better care models, but we expect state gaps to persist without targeted efforts. As telemedicine and remote monitoring become ubiquitous, some granular differences might narrow – for example, rural or low-resource

areas could gain more virtual post-discharge care. Conversely, new challenges (like an aging *baby boomers* peak or persistent opioid-related admissions in certain states) could widen gaps again.

The CVS/Aetna example points to one future direction: **payer-driven solutions**. Large insurers or integrated systems may launch care transition programs in states with high costs. If these prove effective, they may be scaled to wider Medicare populations. Also, given the correlation between nursing home availability and readmissions ([6] pmc.ncbi.nlm.nih.gov), state Medicaid programs may consider incentives for SNF capacity expansion.

Finally, the COVID-19 pandemic introduced additional variables. Many elective cases were deferred in 2020–21, possibly lowering some readmissions temporarily. On the other hand, COVID hospitalizations created new chronic sequelae. A future analysis will be needed to see if COVID exacerbated state disparities (e.g., states hit hardest by early COVID may still be dealing with "long COVID" complications affecting readmissions).

Conclusion

This report reveals that **U.S. state-level hospital readmission rates vary substantially** and for multiple reasons. Some states consistently operate at the high end of the readmission spectrum (Massachusetts, Florida, Illinois, Louisiana, Nevada, West Virginia), while others (Idaho, Utah, Washington) stay below, with others clustered in between. Underlying factors include patient demographics and chronic disease incidence, as well as healthcare system characteristics and community resources. The evidence suggests a model in which readmissions are only partly under the hospital's control: they are a product of systemic and social conditions as much as of clinical care.

Key findings include: Massachusetts averages 15.3% (highest) versus Idaho 13.3% (lowest) readmissions ([3] www.definitivehc.com) ([4] www.definitivehc.com). Studies show that areas with more chronic illness and scarce post-discharge support have higher readmissions ([14] pmc.ncbi.nlm.nih.gov) ([6] pmc.ncbi.nlm.nih.gov). Hospitals in Mid-Atlantic states have up to 1.0 pp higher risk-adjusted rates than those in Mountain states ([8] pmc.ncbi.nlm.nih.gov). These differences have practical implications: one Kaiser analysis found New York's entire hospital system penalized by HRRP far more often than most states ([17] www.empirecenter.org).

For policy and practice, the results imply that readmission-reduction efforts should be **tailored to local context**. State health departments and hospital systems need to collaborate on building post-acute care capacity and addressing social needs. Policymakers should consider adjusting readmission-related incentives to account for regional disparities. Future efforts – from telehealth expansion to value-based care models – should explicitly track how they impact state-level outcomes.

In closing, hospital readmission rates are an important signal of care quality, but they must be interpreted in context. This in-depth study highlights how U.S. states differ in readmissions, and it underscores the need for nuanced, data-driven strategies to ensure high-quality care across every region.

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