Agency for Healthcare Research and Quality
H·CUP | HEALTHCARE COST AND UTILIZATION PROJECT

Costs of Treat-and-Release Emergency Department Visits in the United States, 2021

Statistical Brief #311 | September 2024

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Introduction

Expenditures on hospital care in the United States increased by 11.0 percent from 2019 to 2021[1] despite a decrease in the volume of inpatient stays[2] and emergency department (ED) visits[3,4] during the COVID-19 pandemic. Most hospital inpatient stays in 2021 (59.1 percent) included evidence of ED services prior to admission.[5] Further, in 2021, 18.0 percent of adults in the United States reported that they had an ED visit during the previous 12 months.[6] Therefore, the volume of patient visits to the ED, the associated service delivery costs, and the variation in the volume of ED visits by patient and hospital characteristics remain important health policy concerns.[7]

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents statistics on the cost of treat-and-release ED visits (i.e., visits that did not result in an admission to the same hospital) in the United States. The statistics are based on the 2021 HCUP Nationwide Emergency Department Sample (NEDS). Costs for ED visits were estimated using the HCUP Cost-to-Charge Ratios (CCRs) for ED files and they reflect the expenses incurred in the production of ED services such as wages, salaries, supplies, and utilities. ED visits considered in this Statistical Brief include only patients who were treated and released from the ED, not those who were admitted for an inpatient stay. Aggregate costs, the average cost, and the number of ED visits are presented by patient and hospital characteristics. Because of the large sample size of the NEDS, small differences can be statistically significant. Thus, only percentage differences greater than or equal to 10 percent are discussed in the text.

Highlights

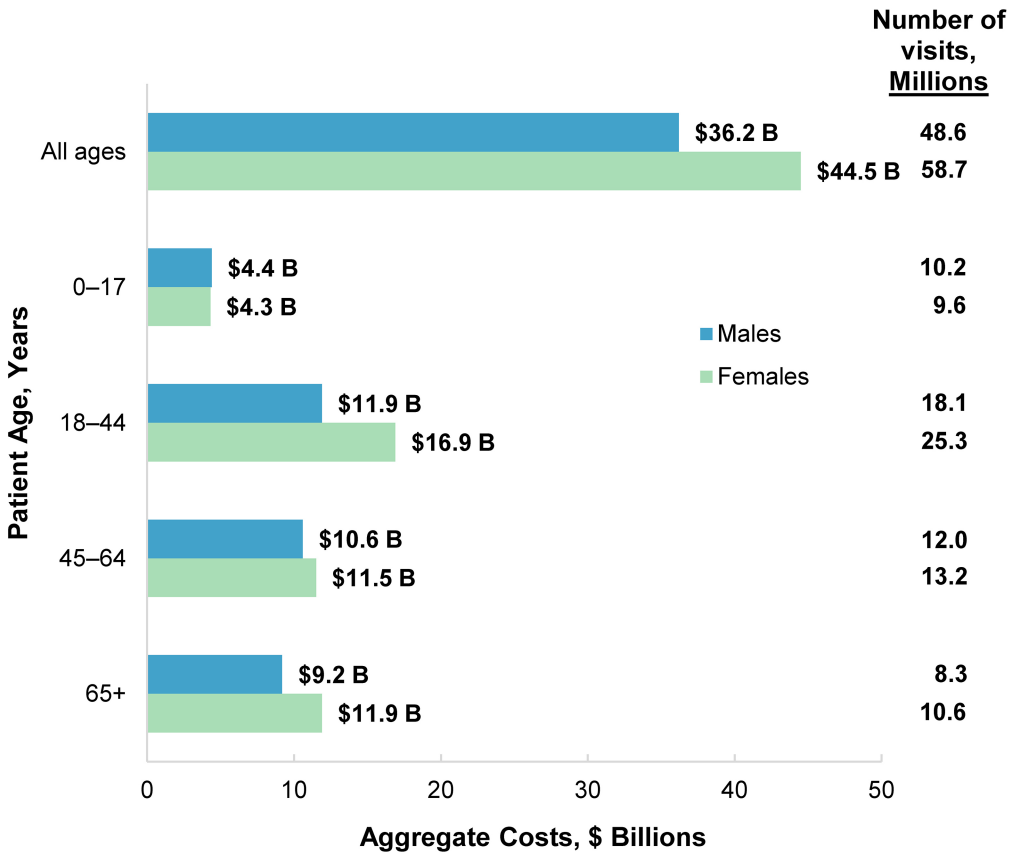
- In 2021, there were 107.4 million treat-and-release emergency department (ED) visits in the United States, with aggregate costs amounting to $80.3 billion (B).
- Aggregate costs were higher for females ($44.5 B) than for males ($36.2 B).
- ED costs for patients residing in large metropolitan areas totaled $42.0 billion in 2021, which represents 52.4 percent of the $80.3 billion spent on treat-and-release ED visits in the United States
- Patients aged 18–44 years represented the largest share of aggregate costs in large metro areas and small metro areas, at 37.1 percent and 36.0 percent, respectively. In rural areas, patients aged 65 and older accounted for the largest share at 35.2 percent.
- ED visits for which the expected payer was private insurance represented the largest share of aggregate ED costs among those living in large metropolitan areas at 34.5 percent. Medicare represented the largest expected cost share for micropolitan areas (33.8 percent) and rural areas (37.4 percent).
- The largest shares of ED visit volume and costs occurred in hospitals in the South, in nonprofit hospitals, in teaching hospitals, and in hospitals that were not trauma centers.

Findings

Aggregate Costs for Treat-and-Release ED Visits by Patient Sex and Age, 2021

Figure 1 presents aggregate costs for treat-and-release ED visits by patient sex and age in 2021.

Figure 1. Aggregate treat-and-release ED visit costs, by patient age and sex, 2021



Abbreviations: ED = emergency department; B = billion.

Notes: Statistics for treat-and-release ED visits with missing or invalid patient characteristics are not presented. Patient age and sex were each missing for <0.1 percent of ED visits. The order of data in the exhibit matches the order of labels in the legend.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2021

- **Aggregate costs for ED visits in 2021 were higher overall for females than they were for males.**

  Of the $80.3 billion in aggregate costs for ED visits in 2021, females accounted for $44.5 billion (55.4 percent), and males accounted for $36.2 billion (45.1 percent). This cost differential was largely driven by a difference in ED visit volume, with females having a larger number of ED visits than males (58.7 visits versus 48.6 million visits). Females had higher aggregate costs for ED visits and a higher number of ED visits than males for the 18–44 and 65 and older age groups. The difference between the sexes was greatest among patients aged 18–44, with the number of ED visits being 39.8 percent greater and the aggregate ED visit costs being 42.0 percent greater for females.

Cost of Treat-and-Release ED Visits by Patient Characteristics, 2021

Table 1 presents the aggregate costs and the average cost for treat-and-release ED visits and the number of ED visits by select patient characteristics in 2021. The distribution of aggregate costs and visits is also presented.

Table 1. Aggregate costs, average cost per visit, and number of treat-and-release ED visits, by patient characteristic, 2021

Patient Characteristic	Aggregate costs		Average cost per visit, $	Number of visits	
	$, billions	%		N, millions	%
Total	**80.3**	**100.0**	**750**	**107.4**	**100.0**
Age group, years					
0–17	8.7	10.8	440	19.8	18.5
18–44	28.8	35.7	660	43.4	40.4
45–64	22.2	27.4	880	25.2	23.4
65+	21.1	26.1	1,110	19.0	17.7
Sex					
Female	44.5	55.1	760	58.7	54.7
Male	36.2	44.9	740	48.6	45.3
Primary expected payer					
Medicare	22.5	27.9	1,040	21.5	20.1
Medicaid	21.4	26.6	600	35.6	33.2
Private insurance	25.9	32.1	790	32.8	30.6
Self-pay/No charge*	7.6	9.5	610	12.5	11.7
Other	3.2	4.0	690	4.7	4.4
Community-level income					
Quartile 1 (lowest)	24.4	30.8	670	36.7	34.7
Quartile 2	20.3	25.6	720	28.2	26.8
Quartile 3	18.7	23.5	810	23.1	21.9
Quartile 4 (highest)	15.9	20.1	910	17.5	16.6
Location of patient's residence					
Large metropolitan area	42.0	52.4	790	53.2	49.9
Small metropolitan area	23.7	29.5	700	33.7	31.6
Micropolitan areas	8.4	10.5	710	11.8	11.1
Rural area	6.1	7.6	770	7.9	7.4
Discharge status					
Routine discharge	71.1	87.9	710	99.7	92.8
Transfer†	6.6	8.2	1,560	4.2	3.9
All other dispositions‡	3.1	3.9	900	3.5	3.2

Abbreviation: ED = emergency department.

Notes: Statistics for treat-and-release ED visits with missing or invalid patient characteristics are not presented. Patient age, sex, expected payer, and community-level income were missing for <0.1 percent, <0.1 percent, 0.2 percent, and 1.7 percent of ED visits, respectively. Charges, from which costs are estimated, were missing for 0.6 percent of ED visits (weighted); see Definitions section.

* Includes self-pay, no charge, charity, and no expected payment.

† Includes both transfer to a different short-term hospital and transfer to other facilities such as skilled nursing facilities, intermediate care facilities, and another type of facility.

‡ Includes home healthcare, against medical advice, died in the ED, and destination unknown.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2021

- **In 2021, aggregate costs for ED visits totaled $80.3 billion across 107.4 million treat-and-release ED visits, with an average cost per visit of $750.**

  Aggregate costs for treat-and-release ED visits totaled $80.3 billion in the United States in 2021, encompassing 107.4 million ED visits with an average cost per visit of $750.

- **The average cost per visit was lowest for children and highest for those in the 65 and older age group.**

  The average cost per ED visit increased with age; the average cost was $440 for children and $1,110 for patients aged 65 and older.

- **Medicare and Medicaid together accounted for 54.4 percent of ED visits and 55.3 percent of aggregate costs.**

  Among primary expected payers, Medicare had the highest average cost per ED visit at $1,040. Medicaid as the primary expected payer had an average cost of $600, which was 42.3 percent lower than Medicare.

- **With increasing community-level income, the share of visits and aggregate costs decreased and the average cost per visit increased.**

  The share of ED visits and ED visit costs decreased as community-level income increased. Patients residing in the lowest income communities (quartile 1) represented 30.8 percent of aggregate ED visit costs and 36.7 percent of ED visits. Patients residing in the highest income communities (quartile 4) constituted 20.1 percent of aggregate ED costs and 17.5 percent of ED visits. However, the average cost per visit increased as community-level income increased, ranging from $670 in communities with the lowest income (quartile 1) to $910 in communities with the highest income (quartile 4).

- **The greatest proportion of ED visits and aggregate costs for ED visits was composed of patients residing in large metropolitan areas.**

  Aggregate costs for patients residing in large metropolitan areas totaled $42.0 billion in 2021, which was 52.4 percent of the $80.3 billion in costs for ED visits for the entire United States. In addition, about half of ED visits (53.2 percent) were for residents of these areas. The average cost ranged from $700 per visit for residents of small metropolitan areas to $790 per visit for residents of large metropolitan areas.

- **Routine discharge was the most frequent discharge status for patients who were treated and released from the ED. There were 99.7 million total routine discharge visits, which accounted for 92.8 percent of all treat-and-release ED visits in the United States.**

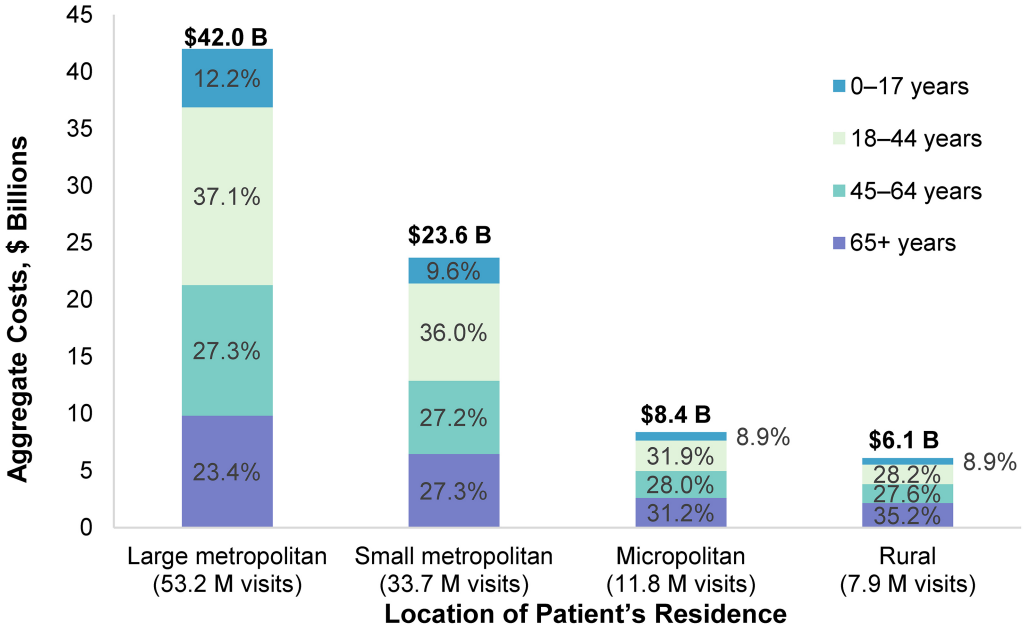
  Of the 107.4 million treat-and-release ED visits in the United States in 2021, 92.8 percent were routine discharges and 3.9 percent were transfers. The cost per visit was substantially higher for transfers than it was for routine discharges ($1,560 vs. $710).

Distribution of Aggregate Costs for ED Visits by Location of Patient Residence and Select Patient Characteristics, 2021

Figures 2, 3, and 4 present the distribution of aggregate costs for treat-and-release ED visits by the location of the patient's residence and patient age (Figure 2), by community-level income (Figure 3), and by primary expected payer (Figure 4).

Figure 2 presents the distribution of aggregate costs for treat-and-release ED visits by the location of the patient's residence in 2021 and patient age group.

Figure 2. Distribution of aggregate costs for treat-and-release ED visits by patient location and age group, 2021



Abbreviations: B = billion; M = million.

Notes: Statistics for the <0.1 percent of ED visits with missing or invalid patient age are not presented. Charges, from which costs are estimated, were missing for 0.6 percent of ED visits (weighted); see Definitions section. The order of data in the exhibit matches the order of labels in the legend.

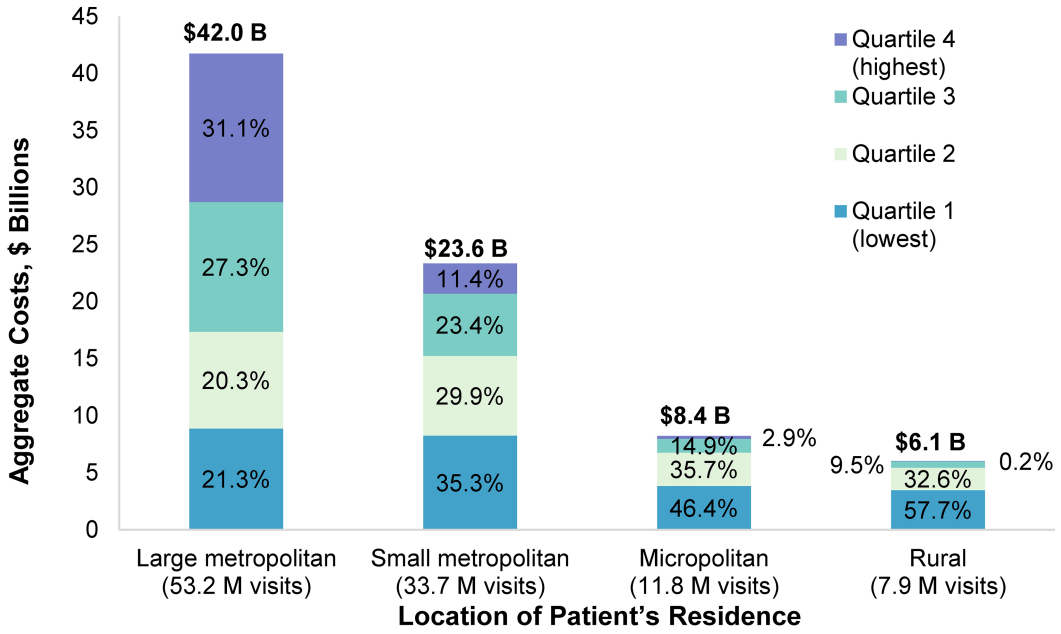
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2021

- **In 2021, patients aged 65 and older accounted for 23.4 percent of costs for treat-and-release ED visits in large metropolitan areas and 35.2 percent of these costs in rural areas.**

  The composition of costs generally shifted to older age groups with increasing rurality and to younger age groups with increasing urbanization. In rural areas, patients aged 65 and older accounted for the largest share, at 35.2 percent, which decreased to 27.3 percent in small metropolitan areas and 23.4 percent in large metropolitan areas. In contrast, patients aged 18–44 accounted for 37.1 percent of the costs in large metropolitan areas and 28.2 percent of the costs in rural areas.

Figure 3 presents the distribution of aggregate costs for treat-and-release ED visits by quartile of median household income in the ZIP Code of the patient's residence in 2021.

Figure 3. Distribution of aggregate costs for treat-and-release ED visits by community-level income and patient location, 2021



Abbreviations: B = billion; M = million.

Notes: Statistics for the 1.7 percent of ED visits with missing community-level income are not presented. Charges, from which costs are estimated, were missing for 0.6 percent of ED visits (weighted); see Definitions section. The order of data in the exhibit matches the order of labels in the legend.

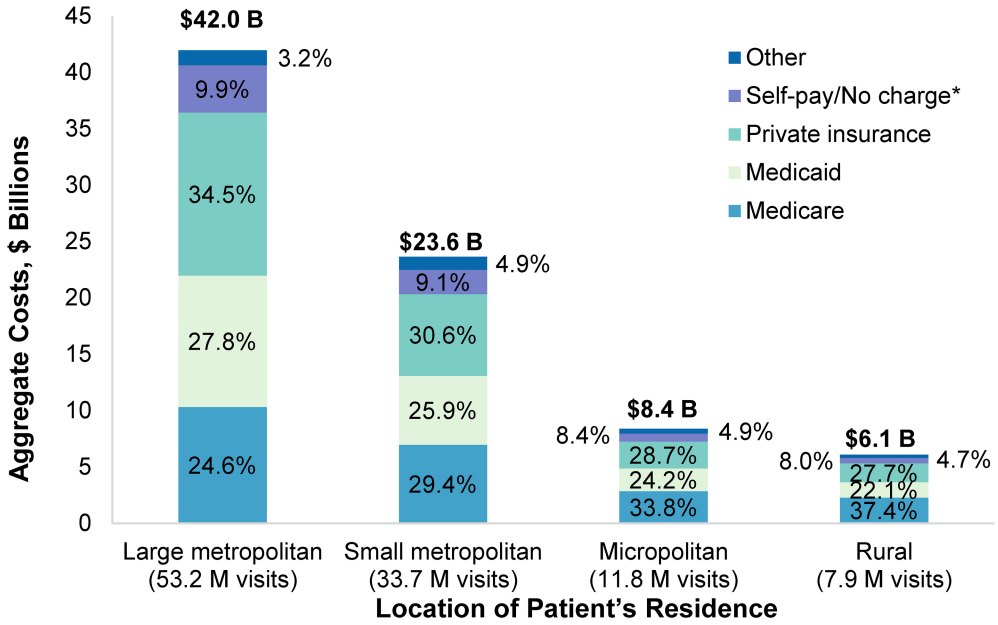
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2021

- **In large metropolitan areas, patients residing in communities with the highest incomes represented the largest share of aggregate costs for treat-and-release ED visits at 31.1 percent.**

  Costs for treat-and-release ED visits generally shifted to lower income communities as rurality increased, and to higher income communities as urbanization increased. Patients residing in communities with the highest incomes (quartile 4) accounted for 31.1 percent of the $42.0 billion in aggregate costs in large metropolitan communities. In contrast, patients in the lowest community income quartile represented the largest share (57.7 percent) of costs in rural areas.

Figure 4 presents the distribution of aggregate costs for treat-and-release ED visits by primary expected payer and the location of the patient's residence in 2021.

Figure 4. Distribution of aggregate costs for treat-and-release ED visits by primary expected payer and patient location, 2021



Abbreviations: B = billion; M = million.

Notes: Statistics for ED visits with missing or invalid patient characteristics are not presented. Expected payer and patient location were missing for 0.2 percent and 0.7 percent of ED visits, respectively. Charges, from which costs are estimated, were missing for 0.6 percent of ED visits (weighted); see Definitions section. The order of data in the exhibit matches the order of labels in the legend.
* Includes self-pay, no charge, charity, and no expected payment.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2021

- **Among primary expected payers, Medicare accounted for the largest share of aggregate costs for treat-and-release ED visits, at more than 30 percent, among patients living in micropolitan and rural areas.**

  Compared with other primary expected payers in 2021, private insurance represented the largest share of aggregate costs, at 34.5 percent, among those living in large metropolitan areas. The share of costs attributed to Medicare increased as rurality increased, from 24.6 percent in large metropolitan areas to 37.4 percent in rural areas.

Costs of ED Visits by Hospital Characteristics, 2021

Table 2 presents aggregate costs, average cost, and the number of treat-and-release ED visits in 2021 by select hospital characteristics.

Table 2. Aggregate costs, average cost per visit, and number of treat-and-release ED visits, by hospital characteristics, 2021

Hospital Characteristic	Aggregate costs		Average cost per visit, $	Number of visits	
	$, billions	%		N, millions	%
Total	**80.3**	**100.0**	**750**	**107.4**	**100.0**
Region					
Northeast	15.6	19.3	820	19.0	17.7
Midwest	18.3	22.7	740	24.9	23.2
South	27.8	34.4	650	42.9	40.0
West	19.1	23.6	930	20.5	19.1
Ownership					
Private, for-profit	7.9	9.7	510	15.3	14.3
Private, nonprofit	61.7	76.4	790	77.9	72.5
Public	11.2	13.9	790	14.2	13.2
Teaching status					
Nonteaching	25.4	31.5	720	35.3	32.8
Teaching	55.4	68.5	770	72.1	67.2
Trauma level designation					
Trauma center level I	15.7	19.4	880	17.8	16.6
Trauma center level II	12.6	15.5	760	16.5	15.4
Trauma center level III	9.7	12.0	660	14.7	13.7
Not a trauma center	42.9	53.1	740	58.3	54.3

Abbreviation: ED = emergency department.

Notes: Average cost has been rounded to the nearest $10. Charges, from which costs are estimated, were missing for 0.6 percent of ED visits (weighted); see Definitions section.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2021

- **The number of treat-and-release ED visits and the aggregate costs for treat-and-release ED visits were highest and the average cost per visit was lowest for hospitals that were located in the South in 2021.**

  Aggregate costs in the South were $27.8 billion in 2021, accounting for 34.4 percent of the $80.3 billion in total ED visit costs in the United States. The share of ED visit volume in the South was even larger, accounting for 40.0 percent of the 107.4 million visits in the United States.

  The lowest average cost per ED visit in 2021 was in private, for-profit hospitals, at $510 per ED visit. The average cost for ED visits in private nonprofit and public hospitals, at $790 per visit, was more than 50 percent higher than the cost at private for-profit hospitals.

  The distribution of aggregate costs for ED visits across other hospital characteristics largely followed the pattern observed in the volume of ED visits. Shares of aggregate costs were highest in private nonprofit hospitals, teaching hospitals, and hospitals that were not designated as trauma centers (76.4 percent, 68.5 percent, and 53.1 percent of costs, respectively).

References

[1] Hartman M, Martin AB, Whittle L, Catlin A. National health care spending in 2022: growth similar to prepandemic rates. Health Aff (Millwood). 2024 Jan;43(1):6-17. doi:10.1377/hlthaff.2023.01360.

[2] American Hospital Association. Fast Facts on U.S. Hospitals, 2021. AHA Hospital Statistics, 2021 Edition. Chicago, IL: American Hospital Association; 2021.

[3] Cairns C, Kang K. National Hospital Ambulatory Medical Care Survey: 2021 Emergency Department Summary Tables. https://www.cdc.gov/nchs/data/nhamcs/web_tables/2021-nhamcs-ed-web-tables-508.pdf. Accessed September 9, 2024.

[4] Cairns C, Kang K. National Hospital Ambulatory Medical Care Survey: 2019 Emergency Department Summary Tables. 2022. https://dx.doi.org/10.15620/cdc:115748. Accessed September 9, 2024.

[5] HCUPnet, Healthcare Cost and Utilization Project. Rockville, MD: Agency for Healthcare Research and Quality. https://datatools.ahrq.gov/hcupnet.

[6] National Center for Health Statistics. Percentage of having a hospital emergency department visit in past 12 months for adults aged 18 and over, United States, 2019-2021. National Health Interview Survey. Generated June 24, 2024 from https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html. Accessed September 9, 2024.

[7] Pickens G, Smith MW, McDermott KW, Mummert A, Karaca Z. Trends in treatment costs of U.S. emergency department visits. Am J Emerg Med. 2022 Aug;58:89-94.

Data Source

This Statistical Brief uses data from the HCUP 2021 Nationwide Emergency Department Sample (NEDS). For additional information about the HCUP NEDS, please visit: https://hcup-us.ahrq.gov/db/nation/neds/nedsdbdocumentation.jsp.

Definitions

Total costs and charges

Charges represent what the hospital billed for the discharge. Hospital charges reflect the amount the hospital charged for the entire ED visit and do not include professional (physician) fees.

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).[a] *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. For the purposes of this Statistical Brief, costs are reported to the nearest $10. Further information on the Cost-to-Charge Ratio can be found at: https://hcup-us.ahrq.gov/db/ccr/costtocharge.jsp.

Charges, from which costs are estimated, were missing for 0.6 percent of ED visits (weighted). Aggregate costs were estimated as the product of the number of visits and the average cost per visit in each reporting category. Therefore, a comparison of aggregate cost estimates across different tables, figures, or characteristics may result in slight discrepancies.

[a] Agency for Healthcare Research and Quality. Cost-to-Charge Ratio (CCR) Files. Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality. Updated November 2021. www.hcup-us.ahrq.gov/db/state/costtocharge.jsp. Accessed September 9, 2024.

Primary expected payer

To make coding uniform across all HCUP data sources, the primary expected payer combines detailed categories into general groups:

- Medicare: includes fee-for-service and managed care Medicare
- Medicaid: includes fee-for-service and managed care Medicaid
- Private insurance: includes commercial nongovernmental payers, regardless of the type of plan (e.g., private health maintenance organizations [HMOs], preferred provider organizations [PPOs])
- Self-pay/No charge: includes self-pay, no charge, charity, and no expected payment
- Other payers: includes other Federal and local government programs (e.g., TRICARE, CHAMPVA, Indian Health Service, Black Lung, Title V) and Workers' Compensation

ED visits that were expected to be billed to the State Children's Health Insurance Program (SCHIP) are included under Medicaid.

Community-level income

Community-level income is based on the median household income of the patient's ZIP Code of residence. Quartiles are defined so that the total U.S. population is evenly distributed. Cutoffs for the quartiles are determined annually using ZIP Code demographic data obtained from projections of the U.S. Census Bureau data.[b] The value ranges for the income quartiles vary by year. The income quartile is missing for patients who are homeless or foreign.

Location of patients' residence

Place of residence is based on the urban-rural classification scheme for U.S. counties developed by the National Center for Health Statistics (NCHS). For this Statistical Brief, we collapsed the NCHS categories into either urban or rural according to the following:

Urban:

- Large central metropolitan: includes metropolitan areas with 1 million or more residents
- Large fringe metropolitan: includes counties of metropolitan areas with 1 million or more residents
- Medium and small metropolitan: includes areas with 50,000–999,999 residents

Rural:

- Micropolitan and noncore: includes nonmetropolitan counties (i.e., counties with no town greater than 50,000 residents)

Discharge status

Discharge status reflects the disposition of the patient at discharge from the hospital and includes the following six categories: routine (to home); transfer to another short-term hospital; other transfers (including skilled nursing facility, intermediate care, and another type of facility such as a nursing home); home healthcare; against medical advice (AMA); or died in the hospital. For the purposes of this Statistical Brief, the "transfer" category includes both transfer to a different short-term hospital and transfer to other facilities such as skilled nursing facilities, intermediate care facilities, and another type of facility; and "all other dispositions" includes home healthcare, against medical advice, died in the ED, and destination unknown.

[b] Claritas. Claritas Demographic Profile by ZIP Code. https://claritas360.claritas.com/mybestsegments/.

Hospital region

Region is one of the four regions defined by the U.S. Census Bureau:

- Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
- Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
- South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Hospital ownership

Data on hospital ownership were obtained from the American Hospital Association (AHA) Annual Survey. Hospital ownership/control includes categories for government nonfederal (public), private not-for-profit (voluntary), and private investor-owned (proprietary).

Hospital teaching status

Data on status as a teaching hospital were obtained from the AHA Annual Survey. *Teaching hospital* is defined as having a residency program approved by the Accreditation Council for Graduate Medical Education, being a member of the Council of Teaching Hospitals, or having a ratio of full-time equivalent interns and residents to beds of 0.25 or higher.

Hospital trauma level

Trauma designation for trauma centers that treat adults and children were identified through the Trauma Information Exchange Program (TIEP) database, a national inventory of trauma centers in the United States.[c] A trauma center is a hospital that is equipped to provide comprehensive emergency medical services 24 hours a day, 365 days per year to patients with traumatic injuries. In 1976, the American College of Surgeons Committee on Trauma (ACS/COT) defined five levels of trauma centers:[d]

- Level I centers have comprehensive resources, are able to care for the most severely injured, and provide leadership in education and research.
- Level II centers have comprehensive resources and are able to care for the most severely injured, but do not provide leadership in education and research.
- Level III centers provide prompt assessment and resuscitation, emergency surgery, and, if needed, transfer to a level I or II center.
- Level IV/V centers provide trauma support in remote areas in which no higher level of care is available. These centers resuscitate and stabilize patients and arrange transfer to an appropriate trauma facility.

For this Statistical Brief, trauma hospitals were defined as those classified by the ASC/COT as a level I, II, or III trauma center. This approach is consistent with the classification of trauma centers used in the NEDS. The ACS/COT has a program that verifies hospitals as trauma level I, II, or III.[e] It is important to note that although all level I, II, and III trauma centers offer a high level of trauma care, there may be differences in the specific services and resources offered by hospitals of different levels. Trauma levels IV and V are designated at the State level (and not by ACS/COT) with varying criteria applied across States.

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[c] American Trauma Society. Trauma Information Exchange Program (TIEP). www.amtrauma.org/page/TIEP. Accessed September 9, 2024.
[d] MacKenzie EJ, Hoyt DB, Sacra JC, Jurkovich GJ, Carlini AR, Teitelbaum SD, Teter H Jr. National inventory of hospital trauma centers. JAMA. 2003 Mar 26;289(12):1515-1522.
[e] American College of Surgeons. Trauma Programs: Verification, Review, and Consultation Program. https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/. Accessed September 9, 2024.

About HCUP

The Healthcare Cost and Utilization Project (HCUP, pronounced “H-Cup”) is a family of healthcare databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of State data organizations, hospital associations, and private data organizations (HCUP Partners) and the Federal government to create a national information resource of encounter-level healthcare data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to healthcare programs, and outcomes of treatments at the national, State, and local market levels. For more information about HCUP, see: https://hcup-us.ahrq.gov/.

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

Alaska Department of Health
Alaska Hospital and Healthcare Association
Arizona Department of Health Services
Arkansas Department of Health
California Department of Health Care Access and Information
Colorado Hospital Association
Connecticut Hospital Association
Delaware Division of Public Health
District of Columbia Hospital Association
Florida Agency for Health Care Administration
Georgia Hospital Association
Hawaii Laulima Data Alliance
Hawaii University of Hawai’i at Hilo
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
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 State Department of Health
Missouri Hospital Industry Data Institute
Montana Hospital Association
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 Authority
Pennsylvania Health Care Cost Containment Council
Rhode Island Department of Health
South Carolina Revenue and Fiscal Affairs Office
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 Department of Health and Human Resources
Wisconsin Department of Health Services
Wyoming Hospital Association

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For More Information

For more information on this and other topics, please visit our HCUP Statistical Briefs topic area page located at www.hcup-us.ahrq.gov/reports/statbriefs/sbtopic.jsp.

For additional HCUP statistics, visit:

- HCUP Fast Stats at https://datatools.ahrq.gov/hcup-fast-stats for easy access to the latest HCUP-based statistics for healthcare information topics
- HCUPnet, HCUP's interactive query system, at https://datatools.ahrq.gov/hcupnet
- HCUP Summary Trend Tables at https://hcup-us.ahrq.gov/reports/trendtables/summarytrendtables.jsp for monthly information on hospital utilization

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 healthcare 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 email us at hcup@ahrq.gov or send a letter to the address below:

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