

# Improving Hospital Discharge Procedures and Follow-up Care of Premature Infants

This Act directs the state Medicaid Program and Children’s Health Insurance Program to improve discharge and follow-up care for infants born in hospitals and who are born earlier than thirty-seven weeks gestational age. The Act directs the state Medicaid Program and the Children's Health Insurance Program to use guidance from the Centers for Medicare and Medicaid Services' Neonatal Outcomes Improvement Project to implement programs to improve such processes. The goal is to ensure standardized and coordinated processes are followed when such infants leave the hospital.

Submitted as:

Mississippi

[HB 1449](#)

Status: Enacted into law in 2009.

## Suggested State Legislation

(Title, enacting clause, etc.)

1           Section 1. [*Short Title.*] This Act shall be cited as “An Act to Improve Post-Discharge  
2 Care for Babies Born Prematurely in Hospitals.”  
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4           Section 2. [*Legislative Findings.*] The [Legislature] finds:

5           (1) According to the Institute for Medicine, although there has been significant attention  
6 focused on neonatal intensive care for extremely preterm infants, little attention has been given  
7 to the majority of late-preterm infants born at thirty-four through thirty-six weeks gestational  
8 age. Even though these late-preterm infants may appear larger in size, they are still more  
9 vulnerable to complications and disabilities than full-term infants. All babies born premature,  
10 including late-preterm infants, are at risk for a host of health and developmental issues that can  
11 last into and sometimes beyond childhood.

12           (2) Although there is growing evidence that late-preterm infants are at increased risk for  
13 morbidity and mortality compared to full-term infants, late-preterm infants may not be identified  
14 or managed any differently than full-term infants.

15           (3) Without organized discharge care plans, premature babies are more likely to  
16 experience gaps in health care. These infants require diligent evaluation, monitoring, referral and  
17 early return appointments for both post-neonatal evaluation and also continued long-term follow-  
18 up care.

19           (4) It is important to focus on the care and management of premature infants because the  
20 number of babies born premature at less than thirty-seven weeks gestational age continues to  
21 grow in the United States.

22           (5) In [2005, twelve and seven-tenths of all births were premature at less than thirty-  
23 seven weeks gestational age, or more than five hundred twenty-five thousand infants].

24           (6) The increase in premature birth rates in recent years is primarily associated with a rise  
25 in late-preterm births (thirty-four through thirty-six weeks gestational age), which has increased  
26 [twenty-five percent since 1990 and account for seventy percent of all preterm births]. Although  
27 multiple births have contributed to this rise, [substantial increases in preterm birth rates, and  
28 especially late-preterm rates, have occurred because of singleton birth rates since 1990].

29           (7) Several studies have found that late-preterm infants have greater morbidity and  
30 mortality than full-term infants.

31 (8) Late-preterm infants have a mortality rate that is three times greater than full-term  
32 infants, with the highest risk occurring during the neonatal period.

33 (9) Late-preterm babies have significant differences in clinical outcomes than full-term  
34 infants during the birth hospitalization, including greater risk for temperature instability,  
35 hypoglycemia, respiratory distress, and jaundice.

36 (10) Late-preterm infants have higher rates of rehospitalization during their first full year  
37 of life compared to full-term infants.

38 (11) The costs of premature births are significant. For the initial hospitalization after  
39 birth, the average length of stay for full-term infants was [two and two-tenths days] and the  
40 average cost was [two thousand eighty-seven dollars], whereas late-preterm infants had a  
41 substantially longer average stay of [eight and eight-tenths days] and cost of [twenty-six  
42 thousand fifty-four dollars]. The average cost for late-preterm infants in their first year of life  
43 was [thirty-eight thousand three hundred one dollars] versus [six thousand one hundred fifty-six  
44 dollars] for full-term infants. Late-preterm infants had higher costs across every type of medical  
45 service category compared to full-term infants, including inpatient hospitalizations, well baby  
46 physician office visits, outpatient hospital services, home health care services and prescription  
47 drug use.

48 (12) The most frequent causes of rehospitalization for late-preterm infants are RSV  
49 bronchiolitis, bronchiolitis (cause unspecified), pneumonia (cause unspecified), esophageal  
50 reflux and vascular implant complications.

51 (13) Because all premature infants, and especially late-preterm infants born at thirty-four  
52 through thirty-six weeks gestational age, have higher risks for medical complications and  
53 rehospitalizations compared to full-term infants, stakeholders should examine and improve the  
54 discharge process, follow-up care and management of these infants to foster better health  
55 outcomes and lower risks for re-hospitalizations and complications.

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57 Section 3. [*Developing Standardized and Coordinated Processes to Follow When Infants*  
58 *Born Prematurely in Hospitals are Discharged from the Hospitals.*] The state [Medicaid  
59 Program] and the state [Children’s Health Insurance Program], in consultation with statewide  
60 organizations focused on premature infant healthcare, shall:

61 (1) Examine and improve hospital discharge and follow-up care procedures for premature  
62 infants born earlier than [thirty-seven weeks gestational age] to ensure standardized and  
63 coordinated processes are followed as premature infants leave the hospital from either a Level 1  
64 (well baby nursery), Level 2 (step down or transitional nursery) or Level 3 (neonatal intensive  
65 care unit) unit and transition to follow-up care by a health care provider in the community; and

66 (2) Use guidance from the Centers for Medicare and Medicaid Services' Neonatal  
67 Outcomes Improvement Project to implement programs to improve newborn outcomes, reduce  
68 newborn health costs and establish ongoing quality improvement for newborns.

69 (3) Report data by the [state department of health] using the mandated hospital discharge  
70 data system authorized in [insert citation] about the incidence and cause of rehospitalization in  
71 the first six months of life for infants born premature at earlier than [thirty-seven weeks  
72 gestational age] to the [Chairman of the House Public Health and Human Services Committee  
73 and the Chairman of the Senate Public Health and Welfare Committee].

74  
75 Section 4. [*Severability.*] [Insert severability clause.]

76  
77 Section 5. [*Repealer.*] [Insert repealer clause.]

78  
79 Section 6. [*Effective Date.*] [Insert effective date.]