

seq.), respectively, of subchapter IV of chapter 7 of this title. Titles V, XIX, and XXI of the Act are classified generally to subchapters V (§701 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

The Head Start Act, referred to in subsec. (b)(2)(B), is subchapter B (§§635-657) of chapter 8 of subtitle A of title VI of Pub. L. 97-35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

PRIOR PROVISIONS

A prior section 399L of act July 1, 1944, was renumbered section 399F and is classified to section 280e-4 of this title.

AMENDMENTS

2021—Subsec. (d)(1)(F). Pub. L. 116-292, §2(1)(B), inserted “or school comprehensive allergies and asthma management program” after “epinephrine” in heading; designated introductory provisions as cl. (i), inserted heading, and substituted “in the State satisfy the criteria described in clause (ii) or clause (iii).” for “in the State—”; inserted cl. (ii) heading and introductory provisions; redesignated former cls. (i) to (iii) as subcls. (I) to (III), respectively, of cl. (ii); added cl. (iii); and realigned margins.

Subsec. (d)(3)(E). Pub. L. 116-292, §2(2)(A), inserted “, such as the school nurse” after “individual” in introductory provisions.

Subsec. (d)(3)(E)(i). Pub. L. 116-292, §2(2)(B), inserted “school nurse or” before “principal”.

2015—Subsec. (d)(3)(A). Pub. L. 114-95 made technical amendment to reference in original act which appears in text as reference to section 7801 of title 20.

2013—Subsec. (d)(1)(F), (G). Pub. L. 113-48, §2(1), added subpars. (F) and (G).

Subsec. (d)(3)(E). Pub. L. 113-48, §2(2), added subpar. (E).

2004—Subsecs. (d), (e). Pub. L. 108-377 added subsec. (d) and redesignated former subsec. (d) as (e).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114-95 effective Dec. 10, 2015, except with respect to certain noncompetitive programs and competitive programs, see section 5 of Pub. L. 114-95, set out as a note under section 6301 of Title 20, Education.

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108-377, §3(b), Oct. 30, 2004, 118 Stat. 2204, provided that: “The amendments made by this section [amending this section] shall apply only with respect to grants made on or after the date that is 9 months after the date of the enactment of this Act [Oct. 30, 2004].”

FINDINGS OF 2004 AMENDMENT

Pub. L. 108-377, §2, Oct. 30, 2004, 118 Stat. 2202, provided that: “The Congress finds the following:

“(1) Asthma is a chronic condition requiring lifetime, ongoing medical intervention.

“(2) In 1980, 6,700,000 Americans had asthma.

“(3) In 2001, 20,300,000 Americans had asthma; 6,300,000 children under age 18 had asthma.

“(4) The prevalence of asthma among African-American children was 40 percent greater than among Caucasian children, and more than 26 percent of all asthma deaths are in the African-American population.

“(5) In 2000, there were 1,800,000 asthma-related visits to emergency departments (more than 728,000 of these involved children under 18 years of age).

“(6) In 2000, there were 465,000 asthma-related hospitalizations (214,000 of these involved children under 18 years of age).

“(7) In 2000, 4,487 people died from asthma, and of these 223 were children.

“(8) According to the Centers for Disease Control and Prevention, asthma is a common cause of missed school days, accounting for approximately 14,000,000 missed school days annually.

“(9) According to the New England Journal of Medicine, working parents of children with asthma lose an estimated \$1,000,000,000 a year in productivity.

“(10) At least 30 States have legislation protecting the rights of children to carry and self-administer asthma metered-dose inhalers, and at least 18 States expand this protection to epinephrine auto-injectors.

“(11) Tragic refusals of schools to permit students to carry their inhalers and auto-injectable epinephrine have occurred, some resulting in death and spawning litigation.

“(12) School district medication policies must be developed with the safety of all students in mind. The immediate and correct use of asthma inhalers and auto-injectable epinephrine are necessary to avoid serious respiratory complications and improve health care outcomes.

“(13) No school should interfere with the patient-physician relationship.

“(14) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within minutes. Anaphylaxis occurs in some asthma patients. According to the American Academy of Allergy, Asthma, and Immunology, people who have experienced symptoms of anaphylaxis previously are at risk for subsequent reactions and should carry an epinephrine auto-injector with them at all times, if prescribed.

“(15) An increasing number of students and school staff have life-threatening allergies. Exposure to the affecting allergen can trigger anaphylaxis. Anaphylaxis requires prompt medical intervention with an injection of epinephrine.”

§ 280g-1. Early detection, diagnosis, and treatment regarding deaf and hard-of-hearing newborns, infants, and young children

(a) Statewide newborn, infant, and young child hearing screening, evaluation and intervention programs and systems

The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make awards of grants or cooperative agreements to develop statewide newborn, infant, and young child hearing screening, evaluation, diagnosis, and intervention programs and systems, and to assist in the recruitment, retention, education, and training of qualified personnel and health care providers (including, as appropriate, education and training of family members), for the following purposes:

(1) To develop and monitor the efficacy of statewide programs and systems for hearing screening of newborns, infants, and young children (referred to in this section as “children”); prompt evaluation and diagnosis of children referred from screening programs; and appropriate educational, audiological, medical, and communication (or language acquisition) interventions (including family support), for children identified as deaf or hard-of-hearing, consistent with the following:

(A) Early intervention includes referral to, and delivery of, information and services by organizations such as schools and agencies (including community, consumer, and family-based agencies), in health care settings (including medical homes for children), and in programs mandated by part C of the Indi-

viduals with Disabilities Education Act [20 U.S.C. 1431 et seq.], which offer programs specifically designed to meet the unique language and communication needs of deaf and hard-of-hearing children.

(B) Information provided to families should be accurate, comprehensive, up-to-date, and evidence-based, as appropriate, to allow families to make important decisions for their children in a timely manner, including decisions with respect to the full range of assistive hearing technologies and communications modalities, as appropriate.

(C) Programs and systems under this paragraph shall offer mechanisms that foster family-to-family and deaf and hard-of-hearing consumer-to-family supports.

(2) To continue to provide technical support to States, through one or more technical resource centers, to assist in further developing and enhancing State early hearing detection and intervention programs.

(3) To identify or develop efficient models (educational and medical) to ensure that children who are identified as deaf or hard-of-hearing through screening receive follow-up by qualified early intervention providers or qualified health care providers (including those at medical homes for children), and referrals, as appropriate, including to early intervention services under part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.]. State agencies shall be encouraged to effectively increase the rate of such follow-up and referral.

(b) Technical assistance, data management, and applied research

(1) Centers for Disease Control and Prevention

(A) In general

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make awards of grants or cooperative agreements to provide technical assistance to State agencies or designated entities of States—

(i) to develop, maintain, and improve data collection systems related to newborn, infant, and young child hearing screening, evaluation (including audiologic, medical, and language acquisition evaluations), diagnosis, and intervention services;

(ii) to conduct applied research related to newborn, infant, and young child hearing screening, evaluation, and intervention programs and outcomes;

(iii) to ensure quality monitoring of hearing screening, evaluation, and intervention programs and systems for newborns, infants, and young children; and

(iv) to support newborn, infant, and young child hearing screening, evaluation, and intervention programs, and information systems.

(B) Use of awards

The awards made under subparagraph (A) may be used—

(i) to provide technical assistance on data collection and management, includ-

ing to coordinate and develop standardized procedures for data management;

(ii) to assess and report on the cost and program effectiveness of newborn, infant, and young child hearing screening, evaluation, and intervention programs and systems;

(iii) to collect data and report on newborn, infant, and young child hearing screening, evaluation, diagnosis, and intervention programs and systems for applied research, program evaluation, and policy improvement;

(iv) to identify the causes and risk factors for congenital hearing loss;

(v) to study the effectiveness of newborn, infant, and young child hearing screening, audiologic and medical evaluations and intervention programs and systems by assessing the health, intellectual and social developmental, cognitive, and hearing status of these children at school age; and

(vi) to promote the integration and interoperability of data regarding early hearing loss across multiple sources to increase the flow of information between clinical care and public health settings, including the ability of States and territories to exchange and share data.

(2) National Institutes of Health

The Director of the National Institutes of Health, acting through the Director of the National Institute on Deafness and Other Communication Disorders, shall for purposes of this section, continue a program of research and development on the efficacy of new screening techniques and technology, including clinical studies of screening methods, studies on efficacy of intervention, and related research.

(c) Coordination and collaboration

(1) In general

In carrying out programs under this section, the Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall collaborate and consult with—

(A) other Federal agencies;

(B) State and local agencies, including agencies responsible for early intervention services pursuant to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (Medicaid Early and Periodic Screening, Diagnosis and Treatment Program); title XXI of the Social Security Act [42 U.S.C. 1397aa et seq.] (State Children's Health Insurance Program); title V of the Social Security Act [42 U.S.C. 701 et seq.] (Maternal and Child Health Block Grant Program); and part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.];

(C) consumer groups of, and that serve, individuals who are deaf and hard-of-hearing and their families;

(D) appropriate national medical and other health and education specialty organizations;

(E) individuals who are deaf or hard-of-hearing and their families;

(F) other qualified professional personnel who are proficient in deaf or hard-of-hearing children's language and who possess the specialized knowledge, skills, and attributes needed to serve deaf and hard-of-hearing children, and their families;

(G) third-party payers and managed care organizations; and

(H) related commercial industries.

(2) Policy development

The Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall coordinate and collaborate on recommendations for policy development at the Federal and State levels and with the private sector, including consumer, medical and other health and education professional-based organizations, with respect to newborn and infant hearing screening, evaluation, diagnosis, and intervention programs and systems.

(3) State early detection, diagnosis, and intervention programs and systems; data collection

The Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention shall coordinate and collaborate in assisting States—

(A) to establish newborn, infant, and young child hearing screening, evaluation, diagnosis, and intervention programs and systems under subsection (a); and

(B) to develop a data collection system under subsection (b).

(d) Rule of construction; religious accommodation

Nothing in this section shall be construed to preempt or prohibit any State law, including State laws that do not require the screening for hearing loss of children of parents who object to the screening on the grounds that such screening conflicts with the parent's religious beliefs.

(e) Definitions

For purposes of this section:

(1) The term "audiologic", when used in connection with evaluation, means procedures—

(A) to assess the status of the auditory system;

(B) to establish the site of the auditory disorder, the type and degree of hearing loss, and the potential effects of hearing loss on communication; and

(C) to identify appropriate treatment and referral options, including—

(i) linkage to State coordinating agencies under part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.] or other appropriate agencies;

(ii) medical evaluation;

(iii) assessment for the full range of assistive hearing technologies appropriate for newborns, infants, and young children;

(iv) audiologic rehabilitation treatment; and

(v) referral to national and local consumer, self-help, parent, family, and edu-

cation organizations, and other family-centered services.

(2) The term "early intervention" means—

(A) providing appropriate services for the child who is deaf or hard-of-hearing, including nonmedical services; and

(B) ensuring that the family of the child is—

(i) provided comprehensive, consumer-oriented information about the full range of family support, training, information services, and language acquisition in oral and visual modalities; and

(ii) given the opportunity to consider and obtain the full range of such appropriate services, educational and program placements, and other options for the child from highly qualified providers.

(3) The term "medical evaluation" means key components performed by a physician including history, examination, and medical decisionmaking focused on symptomatic and related body systems for the purpose of diagnosing the etiology of hearing loss and related physical conditions, and for identifying appropriate treatment and referral options.

(4) The term "medical intervention" means the process by which a physician provides medical diagnosis and direction for medical or surgical treatment options for hearing loss or other medical disorders associated with hearing loss.

(5) The term "newborn, infant, and young child hearing screening" means objective physiologic procedures to detect possible hearing loss and to identify newborns, infants, and young children under 3 years of age who require further audiologic and medical evaluations.

(f) Authorization of appropriations

(1) Statewide newborn and infant hearing screening, evaluation and intervention programs and systems

For the purpose of carrying out subsection (a), there are authorized to be appropriated to the Health Resources and Services Administration \$17,818,000 for each of fiscal years 2023 through 2027.

(2) Technical assistance, data management, and applied research; Centers for Disease Control and Prevention

For the purpose of carrying out subsection (b)(1), there are authorized to be appropriated to the Centers for Disease Control and Prevention \$10,760,000 for each of fiscal years 2023 through 2027.

(3) Technical assistance, data management, and applied research; National Institute on Deafness and Other Communication Disorders

For the purpose of carrying out subsection (b)(2), there are authorized to be appropriated to the National Institute on Deafness and Other Communication Disorders such sums as may be necessary for fiscal years 2011 through 2015.

(July 1, 1944, ch. 373, title III, §399M, as added Pub. L. 106-310, div. A, title VII, §702, Oct. 17,

2000, 114 Stat. 1121; amended Pub. L. 111-337, § 2, Dec. 22, 2010, 124 Stat. 3588; Pub. L. 115-71, § 2, Oct. 18, 2017, 131 Stat. 1218; Pub. L. 117-241, § 2, Dec. 20, 2022, 136 Stat. 2332.)

Editorial Notes

REFERENCES IN TEXT

The Individuals with Disabilities Education Act, referred to in subsecs. (a)(1)(A), (3), (c)(1)(B), and (e)(1)(C)(i), is title VI of Pub. L. 91-230, Apr. 13, 1970, 84 Stat. 175. Part C of the Act is classified generally to subchapter III (§1431 et seq.) of chapter 33 of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Social Security Act, referred to in subsec. (c)(1)(B), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles V, XIX, and XXI of the Act are classified generally to subchapters V (§701 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

AMENDMENTS

2022—Subsec. (e)(3). Pub. L. 117-241, §2(1), inserted par. (3) designation before “The term ‘medical evaluation’”.

Subsec. (f)(1). Pub. L. 117-241, §2(2)(A), substituted “\$17,818,000 for each of fiscal years 2023 through 2027” for “\$17,818,000 for fiscal year 2018, \$18,173,800 for fiscal year 2019, \$18,628,145 for fiscal year 2020, \$19,056,592 for fiscal year 2021, and \$19,522,758 for fiscal year 2022”.

Subsec. (f)(2). Pub. L. 117-241, §2(2)(B), substituted “\$10,760,000 for each of fiscal years 2023 through 2027” for “\$10,800,000 for fiscal year 2018, \$11,026,800 for fiscal year 2019, \$11,302,470 for fiscal year 2020, \$11,562,427 for fiscal year 2021, and \$11,851,488 for fiscal year 2022”.

2017—Pub. L. 115-71, §2(a), substituted “Early detection, diagnosis, and treatment regarding deaf and hard-of-hearing newborns, infants, and young children” for “Early detection, diagnosis, and treatment regarding hearing loss in newborns and infants” in section catchline.

Subsec. (a). Pub. L. 115-71, §2(b)(2), substituted “newborn, infant, and young child” for “newborn and infant” and “providers (including, as appropriate, education and training of family members),” for “providers,” in introductory provisions.

Pub. L. 115-71, §2(b)(1), substituted “newborn, infant, and young child” for “newborn and infant” in heading.

Subsec. (a)(1). Pub. L. 115-71, §2(b)(3), in first sentence, substituted “newborns, infants, and young children (referred to in this section as ‘children’)” for “newborns and infants” and “medical, and communication (or language acquisition) interventions (including family support), for children identified as deaf or hard-of-hearing, consistent with the following:” for “and medical interventions for children identified with hearing loss.”; designated second sentence as subpar. (A) and substituted “, and delivery of,” for “and delivery of”, “by organizations such as schools and agencies (including community, consumer, and family-based agencies), in health care settings (including medical homes for children), and in programs mandated” for “by schools and agencies, including community, consumer, and parent-based agencies and organizations and other programs mandated”, and “hard-of-hearing children.” for “hard of hearing newborns, infants, toddlers, and children.”; struck out third sentence which read “Programs and systems under this paragraph shall establish and foster family-to-family support mechanisms that are critical in the first months after a child is identified with hearing loss.”; and added subpars. (B) and (C).

Subsec. (a)(2). Pub. L. 115-71, §2(b)(4), substituted “To continue to provide technical support to States, through one or more technical resource centers, to assist in further developing and enhancing State early hearing detection and intervention programs.” for “To collect data on statewide newborn and infant hearing

screening, evaluation and intervention programs and systems that can be used for applied research, program evaluation and policy development.”

Subsec. (a)(3). Pub. L. 115-71, §2(b)(5), added par. (3) and struck out former par. (3) which read as follows: “Other activities may include developing efficient models to ensure that newborns and infants who are identified with a hearing loss through screening receive follow-up by a qualified health care provider, and State agencies shall be encouraged to adopt models that effectively increase the rate of occurrence of such follow-up.”

Subsec. (b)(1). Pub. L. 115-71, §2(c), made extensive amendments to text and structure of par. (1). Prior to amendments, text of par. (1) read as follows: “The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make awards of grants or cooperative agreements to provide technical assistance to State agencies to complement an intramural program and to conduct applied research related to newborn and infant hearing screening, evaluation and intervention programs and systems. The program shall develop standardized procedures for data management and program effectiveness and costs, such as—

“(A) to ensure quality monitoring of newborn and infant hearing loss screening, evaluation, diagnosis, and intervention programs and systems;

“(B) to provide technical assistance on data collection and management;

“(C) to study the costs and effectiveness of newborn and infant hearing screening, evaluation and intervention programs and systems conducted by State-based programs in order to answer issues of importance to State and national policymakers;

“(D) to identify the causes and risk factors for congenital hearing loss;

“(E) to study the effectiveness of newborn and infant hearing screening, audiologic and medical evaluations and intervention programs and systems by assessing the health, intellectual and social developmental, cognitive, and language status of these children at school age; and

“(F) to promote the sharing of data regarding early hearing loss with State-based birth defects and developmental disabilities monitoring programs for the purpose of identifying previously unknown causes of hearing loss.”

Subsec. (c)(1). Pub. L. 115-71, §2(d)(1), substituted “consult with—” for “consult with”, “(A) other Federal” for “other Federal”, “(B) State and local agencies, including agencies” for “State and local agencies, including those”, “(C) consumer groups of, and that serve,” for “consumer groups of and that serve”, “(D) appropriate national” for “appropriate national”, “(E) individuals who are deaf or” for “persons who are deaf and”, “(F) other qualified” for “other qualified”, “children,” for “newborns, infants, toddlers, children,” “(G) third-party” for “third-party”, and “(H) related commercial” for “related commercial”.

Subsec. (c)(3). Pub. L. 115-71, §2(d)(2), substituted “States—” for “States”, “(A) to establish newborn, infant, and young child” for “to establish newborn and infant”, “subsection (a); and” for “subsection (a) and”, and “(B) to develop” for “to develop”.

Subsec. (d). Pub. L. 115-71, §2(e), substituted “that do not” for “which do not” and “parent’s” for “parents” and struck out “newborn infants or young” after “hearing loss of”.

Subsec. (e)(1). Pub. L. 115-71, §2(f)(1), made extensive amendments to text and structure of par. (1). Prior to amendments, par. (1) read as follows: “The term ‘audiologic evaluation’ refers to procedures to assess the status of the auditory system; to establish the site of the auditory disorder; the type and degree of hearing loss, and the potential effects of hearing loss on communication; and to identify appropriate treatment and referral options. Referral options should include linkage to State coordinating agencies under part C of the Individuals with Disabilities Education Act or other appropriate agencies, medical evaluation, hearing aid/

sensory aid assessment, audiologic rehabilitation treatment, national and local consumer, self-help, parent, and education organizations, and other family-centered services.”

Subsec. (e)(2). Pub. L. 115-71, §2(f)(4), made extensive amendments to text and structure of par. (2). Prior to amendments, par. (2) read as follows: “The term ‘early intervention’ refers to providing appropriate services for the child with hearing loss, including nonmedical services, and ensuring that families of the child are provided comprehensive, consumer-oriented information about the full range of family support, training, information services, and language and communication options and are given the opportunity to consider and obtain the full range of such appropriate services, educational and program placements, and other options for their child from highly qualified providers.”

Pub. L. 115-71, §2(f)(2), (3), redesignated par. (3) as (2) and struck out former par. (2) which read as follows: “The terms ‘audiologic rehabilitation’ and ‘audiologic intervention’ refer to procedures, techniques, and technologies to facilitate the receptive and expressive communication abilities of a child with hearing loss.”

Subsec. (e)(3). Pub. L. 115-71, §2(f)(5), substituted “The term ‘medical evaluation’ means key components performed by a physician including history, examination, and medical decisionmaking” for “(3) The term ‘medical evaluation by a physician’ refers to key components including history, examination, and medical decision making”.

Pub. L. 115-71, §2(f)(3), redesignated par. (4) as (3). Former par. (3) redesignated (2).

Subsec. (e)(4). Pub. L. 115-71, §2(f)(6), substituted “means” for “refers to”, “or surgical” for “and/or surgical”, and “for hearing loss or other medical disorders” for “of hearing loss and/or related medical disorder”.

Pub. L. 115-71, §2(f)(3), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (e)(5). Pub. L. 115-71, §2(f)(7), substituted “The term ‘newborn, infant, and young child hearing screening’ means” for “The term ‘newborn and infant hearing screening’ refers to” and “, infants, and young children under 3 years of age” for “and infants”.

Pub. L. 115-71, §2(f)(3), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Subsec. (e)(6). Pub. L. 115-71, §2(f)(3), redesignated par. (6) as (5).

Subsec. (f)(1). Pub. L. 115-71, §2(g)(1), substituted “\$17,818,000 for fiscal year 2018, \$18,173,800 for fiscal year 2019, \$18,628,145 for fiscal year 2020, \$19,056,592 for fiscal year 2021, and \$19,522,758 for fiscal year 2022.” for “such sums as may be necessary for fiscal years 2011 through 2015.”

Subsec. (f)(2). Pub. L. 115-71, §2(g)(2), substituted “\$10,800,000 for fiscal year 2018, \$11,026,800 for fiscal year 2019, \$11,302,470 for fiscal year 2020, \$11,562,427 for fiscal year 2021, and \$11,851,488 for fiscal year 2022.” for “such sums as may be necessary for fiscal years 2011 through 2015.”

2010—Pub. L. 111-337, §2(1), substituted “newborns and infants” for “infants” in section catchline.

Subsec. (a). Pub. L. 111-337, §2(2)(A), substituted “screening, evaluation, diagnosis, and intervention programs and systems, and to assist in the recruitment, retention, education, and training of qualified personnel and health care providers,” for “screening, evaluation and intervention programs and systems” in introductory provisions.

Subsec. (a)(1). Pub. L. 111-337, §2(2)(B), amended par. (1) generally. Prior to amendment, par. (1) read as follows: “To develop and monitor the efficacy of statewide newborn and infant hearing screening, evaluation and intervention programs and systems. Early intervention includes referral to schools and agencies, including community, consumer, and parent-based agencies and organizations and other programs mandated by part C of the Individuals with Disabilities Education Act, which offer programs specifically designed to meet the unique language and communication needs of deaf

and hard of hearing newborns, infants, toddlers, and children.”

Subsec. (a)(3). Pub. L. 111-337, §2(2)(C), added par. (3).

Subsec. (b)(1)(A). Pub. L. 111-337, §2(3), substituted “hearing loss screening, evaluation, diagnosis, and intervention programs” for “hearing loss screening, evaluation, and intervention programs”.

Subsec. (c)(2), (3). Pub. L. 111-337, §2(4), substituted “hearing screening, evaluation, diagnosis, and intervention programs” for “hearing screening, evaluation and intervention programs”.

Subsec. (e)(3). Pub. L. 111-337, §2(5)(A), substituted “ensuring that families of the child are provided comprehensive, consumer-oriented information about the full range of family support, training, information services, and language and communication options and are given the opportunity to consider and obtain the full range of such appropriate services, educational and program placements, and other options for their child from highly qualified providers.” for “ensuring that families of the child are provided comprehensive, consumer-oriented information about the full range of family support, training, information services, communication options and are given the opportunity to consider the full range of educational and program placements and options for their child.”

Subsec. (e)(6). Pub. L. 111-337, §2(5)(B), struck out “, after rescreening,” after “infants who”.

Subsec. (f). Pub. L. 111-337, §2(6), substituted “fiscal years 2011 through 2015” for “fiscal year 2002” in pars. (1) to (3).

Statutory Notes and Related Subsidiaries

JAMES T. WALSH UNIVERSAL NEWBORN HEARING SCREENING PROGRAM

Pub. L. 111-8, div. F, title II, §224, Mar. 11, 2009, 123 Stat. 784, provided that: “Hereafter, the activities authorized under section 399M of the Public Health Service Act [42 U.S.C. 280g-1] shall be known as the ‘James T. Walsh Universal Newborn Hearing Screening Program.’”

PURPOSES

Pub. L. 106-310, div. A, title VII, §701, Oct. 17, 2000, 114 Stat. 1120, provided that: “The purposes of this title [enacting this section] are to clarify the authority within the Public Health Service Act [42 U.S.C. 201 et seq.] to authorize statewide newborn and infant hearing screening, evaluation and intervention programs and systems, technical assistance, a national applied research program, and interagency and private sector collaboration for policy development, in order to assist the States in making progress toward the following goals:

“(1) All babies born in hospitals in the United States and its territories should have a hearing screening before leaving the birthing facility. Babies born in other countries and residing in the United States via immigration or adoption should have a hearing screening as early as possible.

“(2) All babies who are not born in hospitals in the United States and its territories should have a hearing screening within the first 3 months of life.

“(3) Appropriate audiologic and medical evaluations should be conducted by 3 months for all newborns and infants suspected of having hearing loss to allow appropriate referral and provisions for audiologic rehabilitation, medical and early intervention before the age of 6 months.

“(4) All newborn and infant hearing screening programs and systems should include a component for audiologic rehabilitation, medical and early intervention options that ensures linkage to any new and existing state-wide systems of intervention and rehabilitative services for newborns and infants with hearing loss.

“(5) Public policy in regard to newborn and infant hearing screening and intervention should be based

on applied research and the recognition that newborns, infants, toddlers, and children who are deaf or hard-of-hearing have unique language, learning, and communication needs, and should be the result of consultation with pertinent public and private sectors.’’

§ 280g-2. Childhood malignancies

(a) In general

The Secretary, acting as appropriate through the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall study environmental and other risk factors for childhood cancers (including skeletal malignancies, leukemias, malignant tumors of the central nervous system, lymphomas, soft tissue sarcomas, and other malignant neoplasms) and carry out projects to improve outcomes among children with childhood cancers and resultant secondary conditions, including limb loss, anemia, rehabilitation, and palliative care. Such projects shall be carried out by the Secretary directly and through awards of grants or contracts.

(b) Certain activities

Activities under subsection (a) include—

(1) the expansion of current demographic data collection and population surveillance efforts to include childhood cancers nationally;

(2) the development of a uniform reporting system under which treating physicians, hospitals, clinics, and States report the diagnosis of childhood cancers, including relevant associated epidemiological data; and

(3) support for the National Limb Loss Information Center to address, in part, the primary and secondary needs of persons who experience childhood cancers in order to prevent or minimize the disabling nature of these cancers.

(c) Coordination of activities

The Secretary shall assure that activities under this section are coordinated as appropriate with other agencies of the Public Health Service that carry out activities focused on childhood cancers and limb loss.

(d) Definition

For purposes of this section, the term “childhood cancer” refers to a spectrum of different malignancies that vary by histology, site of disease, origin, race, sex, and age. The Secretary may for purposes of this section revise the definition of such term to the extent determined by the Secretary to be appropriate.

(e) Authorization of appropriations

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(July 1, 1944, ch. 373, title III, § 399N, as added Pub. L. 106-310, div. A, title XI, § 1101, Oct. 17, 2000, 114 Stat. 1131.)

§ 280g-3. Prescription drug monitoring program

(a) Program

(1) In general

Each fiscal year, the Secretary, acting through the Director of the Centers for Dis-

ease Control and Prevention, in coordination with the heads of other departments and agencies as appropriate, shall support States or localities for the purpose of improving the efficiency and use of PDMPs, including—

(A) establishment and implementation of a PDMP;

(B) maintenance of a PDMP;

(C) improvements to a PDMP by—

(i) enhancing functional components to work toward—

(I) universal use of PDMPs among providers and their delegates, to the extent that State laws allow;

(II) more timely inclusion of data within a PDMP;

(III) active management of the PDMP, in part by sending proactive or unsolicited reports to providers to inform prescribing; and

(IV) ensuring the highest level of ease in use of and access to PDMPs by providers and their delegates, to the extent that State laws allow;

(ii) in consultation with the Office of the National Coordinator for Health Information Technology, improving the intrastate interoperability of PDMPs by—

(I) making PDMPs more actionable by integrating PDMPs within electronic health records and health information technology infrastructure; and

(II) linking PDMP data to other data systems within the State, including—

(aa) the data of pharmacy benefit managers, medical examiners and coroners, and the State’s Medicaid program;

(bb) worker’s compensation data; and

(cc) prescribing data of providers of the Department of Veterans Affairs and the Indian Health Service within the State;

(iii) in consultation with the Office of the National Coordinator for Health Information Technology, improving the interstate interoperability of PDMPs through—

(I) sharing of dispensing data in near-real time across State lines; and

(II) integration of automated queries for multistate PDMP data and analytics into clinical workflow to improve the use of such data and analytics by practitioners and dispensers; or

(iv) improving the ability to include treatment availability resources and referral capabilities within the PDMP.

(2) Legislation

As a condition on the receipt of support under this section, the Secretary shall require a State or locality to demonstrate that it has enacted legislation or regulations—

(A) to provide for the implementation of the PDMP; and

(B) to permit the imposition of appropriate penalties for the unauthorized use and disclosure of information maintained by the PDMP.