



VIA ELECTRONIC SUBMISSION

October 5, 2026

Office of Head Start

ATTN: RIN 0970-AD30, Docket ID ACF-2026-059

Administration for Children and Families

U.S. Department of Health and Human Services

Washington, D.C. 20528

RE: Comments on Reducing Federal Burden for Head Start Programs (RIN: 0970-AD30; Docket ID: ACF-2026-0595)

The Center for Children and Families (CCF), part of the McCourt School of Public Policy at Georgetown University, is an independent, nonpartisan policy and research center that conducts research, develops strategies, and offers policy solutions to support access to high-quality, comprehensive, and affordable health coverage for the nation's children and families, particularly those with low- and moderate incomes. CCF faculty and staff hold decades of expertise in child and family health related to public insurance programs, particularly Medicaid. In response to the Department of Health and Human Services' (HHS) Notice of Proposed Rulemaking (NPRM), our comments below outline our **strong opposition** to the changes proposed to the Head Start Program Performance Standards published in the Federal Register on August 7, 2026.

Head Start has served millions of young children and their families for more than six decades, uniting early learning with health, mental health, nutrition, and family support. Efforts to simplify program requirements should preserve consistent safeguards and the comprehensive services that produce strong results for children and families. Experts have touted Head Start's family- and community-based track record in promoting early relational health central to children's flourishing.¹ Weaker Head Start standards would, in effect, remove what makes Head Start effective for the children it serves: the foundational recognition that positive early child development is rooted in the relationships and environments that surround each child.

Head Start and Medicaid

Medicaid, along with the smaller Children's Health Insurance Program (CHIP) play an outsized role in ensuring young children's access to needed health care, covering nearly three-fourths of the nation's

¹ Backes, E.P., Willis, D. and National Academies of Sciences, Engineering, and Medicine, 2025. Opportunities for Policies and Investments to Advance Early Relational Health. In *Early Relational Health: Building Foundations for Child, Family, and Community Well-Being*. National Academies Press (US). Available [here](#).

young, low-income children under age six.² The Office of Head Start estimates that more than 95% of children enrolled in Early Head Start or Head Start had health insurance, primarily through Medicaid or the Children's Health Insurance Program (CHIP).³

Medicaid and Head Start have worked in partnership for nearly sixty years to prioritize the health and well-being of young children and their families in their communities. Early evaluations of Head Start programs, along with identified preventable disease among Selective Service draftees, led to the creation of Medicaid's comprehensive pediatric benefit, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), in 1967.⁴ In its early years, Head Start sites documented young children who were behind developmentally and showing signs of physical and mental health conditions which, left untreated, could carry lifelong challenges.⁵

As Medicaid EPSDT and Head Start have grown and evolved, statutory language and rules have similarly evolved to reinforce such partnership. Collaboration with state and local agencies, including Medicaid, and support in accessing health care is explicit in the current Head Start standards to fulfill the program's statutory responsibility to ensure health screenings and facilitate connections to health services and a medical home for each child.⁶ The Medicaid statute specifies Head Start as one of the programs states may allow to assist with child Medicaid enrollment, and names Head Start among required programs for collaboration in rulemaking.^{7, 8}

Under Medicaid EPSDT, states are responsible to inform families of its availability for children, from screenings to any identified diagnostic or treatment services.⁹ With its comprehensive support to families of enrolled children, Head Start has long been a contributor to EPSDT outreach and screening facilitation -- a reciprocal obligation and activity clarified in Head Start's comprehensive rules under specified timelines.¹⁰ Head Start standards also prioritize health and developmental screening and service linkages, including expressly for dental and mental health, also required under Medicaid EPSDT

² Source: Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2024 American Community Survey (ACS) Public Use Microdata Sample (PUMS). Based on the documented underreporting of Medicaid in the Census ACS data, this estimate is likely an undercount. For example see Hess, R. (2021). Tracking the Medicaid undercount in the 2021 ACS coverage data. State Health Access Data Assistance Center. Available [here](#).

³ Office of Head Start. Head Start Program Facts: Fiscal Year 2024. Administration for Children and Families, U.S. Department of Health and Human Services. Accessed October 2026. Available [here](#).

⁴ Perkins, J., & Somers, S. (2021). Medicaid's Gold Standard Coverage for Children and Youth: Past, Present, and Future. *Annals Health L. & Life Scis.*, 30, 153. Available [here](#).; and Rosenbaum, S. (2016). When Old Is New: Medicaid's EPSDT Benefit at Fifty, and the Future of Child Health Policy. *The Milbank Quarterly*, 94(4), 716-719. doi: 10.1111/1468-0009.12224. Available [here](#).

⁵ Rosenbaum, S. (2016). When Old Is New: Medicaid's EPSDT Benefit at Fifty, and the Future of Child Health Policy. *The Milbank Quarterly*, 94(4), 716-719. doi: 10.1111/1468-0009.12224. Available [here](#).

⁶ See 42 U.S.C. § 9837(c) and 42 U.S.C. § 9837b(a)(2)(A) for example, in addition to current standards.

⁷ 42 CFR 441.61

⁸ See 42 U.S.C. § 1396r-1a(b)(3)(A)(i)(II) which allows Head Start programs to serve as "qualified entities" for Medicaid presumptive eligibility (PE). Nineteen states have adopted PE for children as of January 2025 as cited in Brooks, T. et. al. (2025) Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations. Appendix Table 7. KFF. Available [here](#). See also 42 U.S.C. § 1396a(e)(13)(F)(i) Head Start agencies may be designated as eligible "Express Lane agencies" in states that have adopted the option.

⁹ 42 CFR Part 441 Subpart B

¹⁰ 45 CFR Part 1302 Subpart D Available [here](#).

and of particular urgency to ensure overall health and development. In these and myriad other ways, Head Start helps Medicaid meet its obligations to children.

The comprehensive Head Start standards support the successful implementation of Medicaid's pediatric benefits for those children enrolled. Head Start programs must ensure health insurance and care access for enrollees, most if not all of whom should be income-eligible for Medicaid. The partnership has stimulated greater attention to health and developmental screenings in both the Head Start sites as well as pediatric primary care.

Head Start's Lasting Impact on Child Health and Development

Many studies have documented a range of positive social, economic and other outcomes well into adulthood. Head Start's impact on child and family health showcases its importance to the health care system at large. These include improved access to health care, such as preventive screenings and immunizations and dental check-ups. Mothers served by Early Head Start experienced reductions in maternal depression, while Head Start enrollees have shown improved cognitive and emotional development, improved access to dental checkups, and exhibit positive healthy eating patterns.^{11, 12, 13, 14} Longitudinal research also shows the positive impact of Head Start well into adulthood, demonstrating improved mental health and positive parenting practices, as well as greater educational outcomes.^{15, 16, 17}

Retaining Head Start Performance Standards

Given the strong track record of Early Head Start and Head Start on children's health, we oppose the NPRM to dilute Head Start's Performance Standards on the whole, as early childhood development is not limited to one domain—health, safety, staffing, and funding work together to make Head Start and Early Head Start work for each child and their family. Specific to maternal and child health, the following proposed changes are of particular concern.

Delayed Identification of Health & Developmental Needs (45 CFR 1302.33 & 1302.42)

Removing screening (45 days) and medical/dental home (90 day) tracking timelines: Standardized vision, hearing, behavioral, and developmental screenings detect delays during critical early brain development.

¹¹ Chazan-Cohen, R. et. al, (2007). It takes time: Impacts of Early Head Start that lead to reductions in maternal depression two years later. *Infant Mental Health Journal*, 28(2), 151–170. <https://doi.org/10.1002/imhj.20127>. Available [here](#).

¹² Patel, S. et. al, (2026). Head Start is Essential for Early Childhood Mental Health. Thrive Center for Children, Families, and Communities. Available [here](#).

¹³ Office of Planning, Research, and Evaluation. (2010). Head Start Impact Study Final Report. Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. Available [here](#).

¹⁴ Lee, R. et. al, (2013). "Head Start and Children's Nutrition, Weight, and Health Care Receipt." *Early Childhood Research Quarterly*, 28(4). doi: 10.1016/j.ecresq.2013.06.003. Available [here](#).

¹⁵ Whitmore Schanzenbach, D. and Bauer, L. (2016). The long-term impact of the Head Start program. Brookings Institute. Available [here](#).

¹⁶ Johnson, R. (2010). The Health Returns of Education Policies from Preschool to High School and Beyond. *American Economic Review*, 100(2), 188-94. doi: 10.1257/aer.100.2.188. Available [here](#).

¹⁷ Deming, D. (2009). Early Childhood Intervention and Life-Cycle Skill Development: Evidence from Head Start. *American Economic Journal: Applied Economics*, 1(3), 111-34. Available [here](#).

Eliminating the federal 45-day deadline risks leaving developmental delays or preventable conditions undetected until elementary school, when interventions are more costly and less effective.

Similarly, removing the 90-day tracking mandates for medical/dental homes and follow-up care undermines a program's ability to partner with families to navigate health services – a vital program role. Eliminating the standard further places children at risk of falling through the cracks– leaving conditions like dental caries, asthma, or lead poisoning untreated, ultimately undermining children's ability to arrive at kindergarten ready to learn. Weaker standards and delayed care would drive up costs to treat urgent health conditions and downstream K-12 special education costs.

Access to screenings and timely care is especially important for identifying and supporting connections for children who may have developmental delays or conditions that qualify them for the Individuals with Disabilities Education Act (IDEA) early intervention or IDEA preschool special education.¹⁸ Relatedly, the proposed rule eliminates all standards for meeting the needs of children with disabilities with a single sentence: "A program must comply with all applicable Federal and state statutes and regulations regarding providing services for children with disabilities."¹⁹ Removing specific timelines for screening and identification requirements removes the detail that makes the expectation actionable, hindering Head Start's ability to serve children with disabilities.

Reduced Access to Mental Health Supports (45 CFR 1302.45)

Under Head Start standards, programs must offer mental health consultation services to support children's emotional and social growth. They must bring together different specialists, make sure children get screened, and ensure they receive proper follow-up care. These standards require continuous mental health consultations and build local partnerships to connect families with needed resources.

Removing mental health requirements deprives teachers of mental health support for children who exhibit challenging behaviors. This – particularly combined with the NPRM's removal of a prohibition on suspension and expulsion – risks raising suspension and expulsion rates in Head Start, which is often the only early childhood setting equipped and required to support children with specific family stresses or challenges that may impact early childhood mental health.

Diminished Support for Infants & Mothers (45 CFR 1302.80)

Eliminating specific prenatal, perinatal, and postpartum health standards in Early Head Start removes dedicated maternal health support for low-income pregnant women, who already face disparate maternal mortality and other serious health conditions.²⁰ Services for pregnant women – including the critical details about the timing and methods of delivering those services – exist only in the Head Start

¹⁸ 20 U.S.C. §§ 1431–1444, 20 U.S.C. § 1419

¹⁹ Proposed Rule § 1301.10.

²⁰ Declercq, E. and Zephyrin, L. (2025) Maternal Mortality in the United States, 2025. Commonwealth Fund. <https://doi.org/10.26099/kdfd-fc19>. Available [here](#).

standards. By rescinding components related to supporting maternal health and home visiting, HHS's rule risks a reduction in the scope and quality of maternal health services, with potential to create new access barriers to care during pregnancy and postpartum.

The Early Head Start standards reflect the importance of timely care and support for prenatal and postpartum mothers and infants, addressed proactively to promote their well-being and healthy development and prevent complications, given the significance of the perinatal period.

The NPRM also risks reducing the ability of Head Start programs to improve maternal health outcomes in service of child development and school readiness. Maternal mental health is closely tied to children's developmental and behavioral outcomes, including social skills, mental health, and cognitive development.²¹

Removing specific standards will create inconsistencies in how Early Head Start is administered, exacerbating issues of access and health outcomes for all Early Head Start parents, many of whom are members of populations with outcomes that are already far below those of the general population.

These examples above are illustrative but do not capture the many ways Head Start standards and existing administrative funding support work together to address early childhood development across the continuum of systems and services, with the child and family at the center of support.

The proposed rule itself explicitly estimates savings from reductions in the very comprehensive services that address children's health and positive development from pregnancy onward. The proposal's regulatory impact analysis assumes that programs will minimize or stop providing direct health and mental health support. It estimates the decreased services alone will lead to cuts of annual health and mental health spending by an estimated \$111 million. Fewer children and families will, in turn, access early screenings, timely intervention, and needed care, which would increase Medicaid, health system, and education costs from delayed or untreated care. The move merely reallocates and increases these and other costs to already-strapped state health, human services, or education systems down the line.

Congress and the Centers for Medicare & Medicaid Services (CMS) have prioritized strengthened implementation and oversight of Medicaid's pediatric benefit (EPSDT) to meet its full potential for children enrolled in Medicaid.²² Weakening the Head Start standards, which prioritize access to screenings, health and mental health care, and family support, combined with new spending caps, will further undermine state Medicaid agencies' responsibility to ensure every infant, toddler, and preschooler can get the care they need early enough to mitigate or prevent conditions or developmental

²¹ A. Rogers et al., "Association Between Maternal Perinatal Depression and Anxiety and Child and Adolescent Development: A Meta-analysis," *JAMA Pediatrics* 174, no. 11 (September 2020):1082-1092, available [here](#).

²² S.2938 - Bipartisan Safer Communities Act. (2022). P.L. 117-159. 139 Stat 1313. Available [here](#).

delays. State Medicaid agencies are already under massive pressure, undertaking significant changes to the program amid growing cuts.²³

The proposed rule would not only weaken the quality of Head Start for pregnant women and young children served, but will also reduce their access to and utilization of needed health care during a critical time of rapid early development and family transition—when they likely need it the most. The potential impact on long-term health and development for the child and the accrued costs across multiple child-serving systems must be considered.²⁴

* * *

Thank you again for the opportunity to comment on the NPRM. Please contact me (elisabeth.burak@georgetown.edu) with any questions.

Respectfully submitted,



Elisabeth Wright Burak
Senior Fellow
Center for Children and Families
McCourt School of Public Policy
Georgetown University

²³ A. Pillai et al. (2026). Medicaid and Upcoming State Budget Debates. KFF. Available [here](#).

²⁴ See for example "In The Child Wars, There Are No Civilians," Health Affairs Forefront, October 2, 2026." Available [here](#).