



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

October 6, 2026

The Honorable Robert F. Kennedy Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

**Re: Reducing Federal Burden for Head Start Programs, Notice of Proposed Rulemaking
(91 Fed. Reg. 51248, Aug. 7, 2026); Docket No. ACF-2026-0595; RIN 0970-AD30**

Dear Secretary Kennedy:

On behalf of the Massachusetts Medical Society (MMS), representing over 20,000 physicians, residents, and medical students, we write to comment on the above-referenced rule that would rescind and replace the Head Start Program Performance Standards. Our comments address the proposal's effects on child and maternal health, access to health care, and other health impacts. Many of our members are pediatricians, family physicians, obstetricians, psychiatrists, and other physicians who care for Head Start children and families every day and who rely on Head Start as a partner in keeping those children healthy.

Summary

MMS urges the Administration for Children and Families (ACF) to withdraw or significantly revise many provisions of this proposal. The rule would rescind Parts 1301 through 1305 and more than 1,400 provisions, replacing them with a substantially pared down Part 1301. In doing so, it would eliminate nearly every federal standard that distinguishes Head Start as a comprehensive child and family health program and not simply an early education program.

ACF states that the rule would "reinforce health and physical development priorities." The regulatory text, however, does not support that claim. The new health provisions are limited to meal service, nutrition conversations with parents, 30 minutes of physical activity per 3.5 hours, lead prevention, and a pared-back set of prenatal education requirements. At the same time, the rule *removes* the requirements that Head Start programs:

- confirm that each child has a source of ongoing health care and is up to date on well-child visits and immunizations (current § 1302.42);
- help families obtain health insurance and navigate the health system, including for enrolled pregnant women (current §§ 1302.42 and 1302.80);
- support daily tooth brushing and connect children to dental care (current § 1302.43);
- provide at least monthly mental health consultation and maintain a Health and Mental Health Services Advisory Committee (current § 1302.45); and,
- help reduce barriers to healthy maternal and birth outcomes and complete newborn visits within two weeks of birth (current §§ 1302.80 and 1302.81).

The Regulatory Impact Analysis (RIA) makes the expected result plain, as ACF itself projects that programs will cut health and mental health spending by about **\$111.3 million per year**. That amount is roughly half of the \$222.7 million that programs now report for health contractual services and health and mental health personnel. These cuts do not result in paperwork savings; they result in fewer health services for young children from low-income backgrounds.

Head Start is Critical to the Child Health Safety Net

Since 1965, Head Start has been designed as a comprehensive program that links health, nutrition, mental health, and family support to early learning. For many families with low incomes, the Head Start classroom is the most reliable point of contact with the health system in the time between well-child visits. Head Start staff notice a missed vaccine, a hearing problem, untreated cavities, or a child's worsening asthma, and they help parents get the care their child needs.

[Head Start promotes better health care coverage and access](#). In fiscal year 2025, 96 percent of Head Start children had health insurance, mostly through Medicaid or CHIP, and 88 percent had ongoing dental care. These rates reflect the very enrollment, health-tracking, and navigation work the proposed rule would stop requiring.

Even with Head Start's services, preventive care is falling behind optimal levels. [HHS' own analysis](#) found that the share of Head Start children up to date on well-child visits fell from 85 percent to 74 percent between FY2016 and FY2025, and the share of children up to date on their immunizations fell from 88 percent to 81 percent. Additionally, the number of new enrollees screened within 45 days fell 38 percent. Removing the standards that drive this work would likely speed up that decline.

Importantly, Head Start has longitudinal health benefit. [Research ties Head Start's health services to lower child mortality](#), finding that counties receiving more Head Start funding in the program's early years saw a 33 to 75 percent reduction in mortality among children ages 5 to 9 from causes that Head Start health services could address, such as respiratory illness, infections, anemia, and malnutrition.

A rule that keeps the classroom but removes the health infrastructure risks giving up the gains that federal investment has achieved as many of the benefits of Head Start come from its health services and not from classroom time alone.

The Proposed Rule Would Harm the Health of Children and Families

1. Loss of the medical home, well-child care, and immunization safeguards

Current § 1302.42 requires programs to determine within 30 days whether each child has ongoing health care, within 90 days whether the child is up to date on the EPSDT schedule, including immunizations, and to help families get needed follow-up care. The proposal removes these requirements, along with the duty to help families obtain insurance and navigate the health system. The Head Start Act's general reference to screenings (Sec. 642(f)(6)) does not replace these safeguards. A screening without follow-up, referral, and tracking does not obtain a hearing aid, glasses, asthma medicine, or a missed vaccine for a child. Pediatricians depend on Head Start staff to help identify needs and secure care and other services, especially for families facing transportation, language, or work-schedule barriers.

2. Loss of oral health services

[According to the CDC](#), tooth decay remains among the most common chronic diseases of childhood and disproportionately affects low-income children. The proposed rule removes all of current § 1302.43, including daily tooth brushing support, and the dental follow-up requirements in § 1302.42.

Untreated decay causes pain, infection, missed school, and emergency department visits, and it can require treatment under general anesthesia. Head Start is one of the few settings that reliably connects young Medicaid-enrolled children to a dental home for prevention.

3. Loss of mental health resources and a return to preschool expulsion

The proposal eliminates monthly mental health consultation and the limits on suspension and expulsion. Together, these changes would remove the main tools that programs use to help young children with behavioral symptoms and would replace them with removal from care. Early childhood mental health consultation is an [evidence-based intervention to reduce expulsion and support teachers](#). Expelling a three- or four-year-old child does not treat the underlying causes of problematic behavior. Instead, expulsion cuts the child off from the very services that are needed and additionally adds stress for the family. Furthermore, national data show that expulsion decisions disproportionately affect children of color and children with disabilities. [According to the U.S. Department of Education](#), in 2020-21, children with disabilities were 24 percent of public preschool enrollment but 62 percent of preschool expulsions, and Black children were 17 percent of enrollees but 31 percent of children suspended.

4. Larger classes and fewer adults

The proposed rule would replace federal ratios and group sizes with state licensing minimums. ACF's own estimate is that, at full adjustment, programs would need about 24 percent fewer teaching staff (80,078 versus 105,423). That means roughly 32 percent more children per teacher, with a \$668 million annual cut in teaching personnel. Fewer adults results in less supervision, slower response to injuries and medical emergencies, and less capacity to manage medication, allergies, seizures, and chronic conditions like asthma and diabetes. It also means fewer chances to notice developmental or health concerns.

5. Weaker infection control and safety protections

The proposed rule also removes Head Start's hygiene, safety, and disaster-preparedness practices (current § 1302.47), staff health exams, and communicable disease screening for staff and volunteers. ACF estimates that about 26 percent of Head Start service locations are not licensed by state childcare agencies. For those sites, only the more limited, basic health and safety requirements would apply. Young children are especially vulnerable to respiratory, gastrointestinal, and vaccine-preventable infections that spread quickly in group care and then to families and communities. Therefore, preserving early infection prevention is crucial to community and public health.

6. Reduced support for pregnant and postpartum women

The proposal removes requirements to assess pregnant individuals' access to health care, to help them get health insurance, to reduce barriers to healthy birth outcomes, to track services, and to complete a newborn visit within two weeks of birth. The first weeks after birth are when many serious maternal complications, including hypertensive disorders, infection, and postpartum depression, appear. Early Head Start is often the most consistent source of support for pregnant individuals with low incomes, and weakening it would work against state and national efforts to reduce maternal morbidity and mortality.

7. Barriers to enrollment for the children with the greatest health needs

The proposed rule would bar self-attestation for eligibility, including for families experiencing homelessness, and remove the option to enroll a child without proof of age. The families least able to

produce documents, such as those who are unhoused, fleeing violence, or recently displaced, are often those whose children have the most unmet health needs. The Head Start Act (Sec. 640(m)) requires HHS to remove barriers to enrolling unhoused children. [In Massachusetts alone, about 1,591 children in Head Start and Early Head Start were experiencing homelessness](#) in Fiscal Year 2024. Prohibiting pathways to eligibility will harm the children and families that Head Start was created to serve.

8. Weaker communication with families about their children's health

The proposed rule requires English-only instruction and removes the requirement that at least one staff member speak the majority home language in a classroom. ACF acknowledges this "may negatively affect communication with non-English speaking families." About [35 percent of Head Start children are dual language learners](#). When staff are not equipped to talk with parents about allergies, medications, symptoms, screening results, or referrals, children's health is put at risk. Delays in needed care can result in higher acuity upon eventual presentation to clinical staff, further straining the health care system's capacity and finances.

9. Broad waivers and a 5 percent administrative cap

Proposed §1301.18 would allow waivers of almost any requirement except nutrition, physical activity, and eligibility. The remaining health, safety, disability, and pregnancy provisions would be waivable if a program simply "stated" that children will not be harmed, with no criteria or data required. Separately, cutting the administrative cost cap from 15 to 5 percent would squeeze the health and family service managers, data systems, and community partnerships that coordinate care with physicians, dentists, and specialists. If such cuts to requirements are to be permitted, it is essential that they are supported by data proving that no harm to children will occur as a result. Data-based decision-making is essential to the health of the Head Start communities.

The Harms Would Fall Hardest on Children Already at Greatest Risk

Head Start serves children whose families live at, or near, the federal poverty line. Nationally, 38 percent of children served are Hispanic or Latino, 29 percent are Black, 3 percent are American Indian or Alaska Native, 15 percent have disabilities, and about 55,000 families served in FY2024 experienced homelessness ([Head Start Program Facts, FY2024](#)). These children already face higher rates of asthma, dental disease, food insecurity, lead exposure, developmental delay, and exposure to trauma, and their parents face more barriers to getting care.

The proposal removes provisions that most directly address these gaps: follow-up care, insurance navigation, mental health consultation, limits on expulsion, and support for healthy birth outcomes. It also removes the requirement that programs address differences in maternal and birth outcomes across racial and ethnic groups (current § 1302.80(f)). [Black women in the United States die from pregnancy-related causes at about three times the rate of White women](#). Removing a requirement to reduce barriers to healthy births will only exacerbate this inequity.

Because the rule leaves so much to state law and local choice, it will also widen differences between states. A child's access to health screening follow-up, mental health consultation, or protection from expulsion would depend on where the child lives, not on what the child needs. The Head Start Performance Standards were created to guarantee a national floor for the nation's most vulnerable young children; this proposal removes that floor.

Cuts to Head Start Would Shift Costs to an Already Strained Health System

The RIA counts reduced spending on health services as a savings to be "reallocated." It does not count the downstream costs. When a child's asthma, dental infection, or developmental delay goes unaddressed, care shifts to emergency departments, hospital admissions, special education, and Medicaid. These are costs borne by states, physicians, hospitals, and families.

The timing adds to the strain as Head Start programs are coping with flat funding and rising costs. [HHS reports](#) that funded slots fell 27 percent from FY2016 to FY2025 and family services staff fell 23 percent. In Massachusetts, the [Commonwealth provided emergency funding in 2025](#) to keep nearly all Head Start programs open during the federal shutdown. At the same time, families are now facing new Medicaid eligibility and renewal requirements. As a result, Head Start staff who help parents keep coverage are now even more important for families in the Head Start program.

Massachusetts Head Start and Early Head Start programs serve over 11,000 children; yet, they reach only 34 percent of eligible preschoolers and 12 percent of eligible infants and toddlers ([First Five Years Fund, 2025](#)). ACF suggests that savings could fund more slots for enrollees. However, adding children while removing the health services is not an expansion of Head Start. It turns a comprehensive program into lower-cost childcare, and it shifts the unmet health needs of those children onto pediatric practices, community health centers, and public health departments that are already stretched thin.

Recommendations

MMS supports sensible efforts to reduce paperwork that do not ultimately help children; however, the health and safety standards in the current rule are not red tape, they are how Head Start delivers on its statutory purpose of promoting "child health services and physical development" (Sec. 641A(a)(2)). Accordingly, we urge ACF to:

1. **Retain the child health standards** in current §§ 1302.42 and 1302.43, including tracking of medical and dental homes, EPSDT and immunization status, follow-up care, insurance and health system navigation, and oral health practices.
2. **Retain mental health consultation** (§ 1302.45) and **the limits on suspension and the prohibition on expulsion** (§ 1302.17).
3. **Retain federal ratio and group size standards** (§ 1302.21), or at minimum study their effect on injury, supervision, and health follow-up before changing them.
4. **Retain services for pregnant and postpartum individuals** (§§ 1302.80 through 1302.82), including insurance assistance, the two-week newborn visit, and efforts to reduce barriers to healthy births.
5. **Retain hygiene, safety, and staff health and communicable disease screening standards** (§ 1302.47 and § 1302.93), especially for license-exempt sites.
6. **Preserve access** by keeping flexible documentation for families experiencing homelessness and for proof of child age and by keeping staff able to communicate with families in their home language on health matters.
7. **Exclude all health, mental health, safety, disability, and pregnancy provisions from the waiver authority** in proposed § 1301.18.
8. **Revise the RIA** to quantify the health costs of reduced services, including avoidable emergency visits, hospital care, and delayed diagnosis, and their distribution across populations.

Conclusion

Head Start is one of the country's most effective investments in the health of young children from low-income backgrounds. As proposed, this rule would weaken that investment by removing the standards that connect children to preventive, dental, and mental health care and that protect them in the classroom. The result would be more unmet health needs, wider disparities, and more strain on the health care safety net. MMS respectfully urges ACF to withdraw these harmful provisions. We welcome the opportunity to work with ACF on reforms that reduce burden while protecting children's health.

Thank you for considering our comments. Please contact Casey Rojas, Federal Relations & Health Equity Director at CRojas@MMS.org with any questions you may have.

Sincerely,

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President, Massachusetts Medical Society