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Agency of Human Services

October 6, 2026

Assistant Secretary Alex J. Adams
Administration for Children and Families
The Honorable Robert F. Kennedy, Jr.
Secretary of United States Department of Health and Human Services
Washington, D.C. 20528

RE: Comment on Notice of Proposed Rulemaking, Reducing Federal Burden for Head Start Programs, 91 Fed. Reg. 51,248 (Aug. 7, 2026), HHS-2026-0595, RIN 0970-AD30

Dear Assistant Secretary Adams:

The State of Vermont appreciates the opportunity to comment on the proposed rule and offers the following concerns for HHS to consider as it evaluates changes to the Head Start Program Performance Standards. We support targeted changes that reduce duplicative reporting, simplify documentation, and allow programs to coordinate effectively with state systems. The scope of the proposed changes raises questions about how essential protections and services would be maintained and how responsibilities might shift across systems. We encourage HHS to consider these implications carefully and assess the fiscal and service consequences for states before finalizing changes.

Head Start combines early education with health, nutrition, developmental, disability, and family support services. Removing a federal requirement does not eliminate the underlying need. It changes whether federally funded Head Start programs must address that need and may transfer responsibility to state agencies, schools, community providers, and families. Vermont encourages HHS to account for potential service losses and costs incurred elsewhere when evaluating whether reduced Head Start expenditures represent an overall efficiency gain.

Vermont is home to seven Head Start recipients and six Early Head Start recipients who provide services across 74 sites to 1,049 funded slots. According to the 2025 Program Information Report (PIR), cumulative enrollment was 1,212 children (649 in Head Start; 563 in Early Head Start, plus 49 pregnant women). These programs are important partners in Vermont's early childhood and human service systems and changes in Vermont Head Start's high-quality service capacity has the potential to increase demands on other state programs such as the Child Care Financial Assistance Program (CCFAP)/CCDF, Reach Up/TANF, 3SquaresVT/SNAP, WIC, Medicaid, Children's Integrated Services (CIS) and IDEA Part C, IDEA Part B, local educational agencies (LEAs), child welfare, and housing and homelessness services. Our concern is that programs would face pressure to increase enrollment with existing resources while providing



lower quality care and less comprehensive support for families. A higher number of funded slots with substantially less assistance is likely to meet the needs of fewer families rather than more.

We recommend that HHS revise its regulatory impact analysis to distinguish actual administrative simplification from reductions in service intensity, staffing, and prevention. The analysis should estimate costs to federal, state, and local systems and families; identify which services state licensing does and does not require; and assess the combined effects of the changes. It should include scenarios in which programs maintain current services, reduce services, or cannot sustain operations under the proposed administrative cap.

Administrative costs and program sustainability

Proposed §1301.14 would reduce allowable costs to develop and administer a Head Start program from fifteen percent to five percent of total approved program costs, including federal funds and non-federal match. This is a two-thirds reduction in the allowable percentage. Vermont is concerned that this reduction may not leave sufficient capacity for necessary administrative functions and recommends retaining the existing limit and waiver flexibility while those implications are assessed.

Sound administration is necessary to operate a safe, fiscally accountable program. Financial management, payroll, procurement, human resources, grant compliance, and governance support do not disappear when their allowable share of a budget is reduced. Programs remain responsible for managing public funds and meeting statutory requirements. An insufficient allowance can undermine their ability to recruit and retain administrative staff, maintain effective internal controls, ensure program integrity, and keep services operating. For smaller rural recipients, fixed administrative responsibilities must be supported across a limited number of children and sites.

Comparisons with five percent limits in state-administered block grants do not establish that the same limit is workable for organizations directly operating Head Start services. Those financing structures are primarily tied to financial benefit programs not comprehensive direct service programs and distribute responsibilities across different entities. We recommend that HHS examine the full administration of each comparison program and the actual duties retained by Head Start recipients before drawing conclusions about equivalent costs. The proposed cap could affect program viability if recipients cannot finance necessary administration without weakening services or drawing support from other sources.

Eligibility, enrollment, and access to sufficient service hours

Vermont is concerned about the potential for changes to create additional barriers for eligible families seeking to enter or remain in Head Start. Proposed §1301.02(c)(4) would prohibit self-attestation for eligibility, while also removing the housing-cost adjustment and the flexibility to enroll a child when the family cannot provide documentation. These changes would create additional barriers for families experiencing homelessness, unstable housing, irregular income, or missing records. They are particularly concerning when the purpose of Head Start is to reach



children facing the greatest barriers to opportunity. The Vermont 2025 PIR reports 264 children who experienced homelessness during enrollment (22% of the 1,212 children served) and 81 who were in foster care at some point during the year (7%) (these are family circumstances experienced while enrolled, distinct from the primary eligibility category recorded at entry). The figures illustrate why practical documentation alternatives and continuity of participation warrant particular attention.

The proposal retains categorical eligibility for children experiencing homelessness and foster care, and statutory eligibility based on qualifying public assistance remains applicable. Nevertheless, eligibility in law does not ensure practical access. A family living temporarily with others may have difficulty obtaining third-party records even though the child meets the applicable homelessness definition. We recommend that HHS preserve reasonable verification alternatives, including documented self-attestation when other evidence is unavailable, and retain explicit instructions allowing children experiencing homelessness to enroll and attend while documentation is gathered. We recommend that HHS retain the housing-cost adjustment or provide a legally supported alternative that recognizes families' actual resources after unusually high housing costs.

Attendance tracking also cannot substitute for attendance support. Rescinding the current requirements for outreach and individualized responses to absenteeism risks losing opportunities to identify transportation problems, housing disruption, illness, or family crisis. Vermont recommends that HHS retain affirmative requirements to help children participate consistently and respond promptly to unexplained absences and safety concerns. In Vermont, 569 of the 917 children cumulatively enrolled in center-based or family child care options had periods in which they were reported as chronically absent (62%). Of those 569 children, 469 remained enrolled due to the attendance support provided. These data do not identify the causes of absence but indicate a substantial need for attendance support alongside tracking.

Removing federal preschool service duration requirements would allow additional short-session configurations. Two three-hour sessions may increase the number of children reported as being served while leaving working families without care for much of the day. Families would have to find additional providers, arrange transportation between settings, or reduce employment. That could increase demand for child care subsidies and scarce child care capacity, and complicate participation in Reach Up/TANF employment activities. Vermont's 2025 PIR reports 663 funded center-based slots meeting the applicable annual-hour threshold; none of the 93 center-based classes operated as double sessions. At enrollment, 648 of the 1,107 families served had at least one parent or guardian employed, in job training, or in school (59%). Programs or their partners received child care subsidies for 646 enrolled children (53%). These figures demonstrate family need for longer sessions and an existing connection between Head Start and Vermont's child care financing system. Reducing hours funded by Head Start would likely increase demand for and cost of CCFAP child care subsidy, transferring costs to other state and federal funding sources.

We recommend that HHS retain meaningful minimum service duration requirements and permit justified exceptions based on community needs and family preferences. Before approving shorter



schedules, we recommend information be collected to determine how children will receive adequate educational and comprehensive services and how families' care needs will be addressed. Measures of access should include hours and weeks of service, continuity, transportation feasibility, and the availability of the comprehensive service package, alongside funded enrollment.

Continuity of preventive health nutrition and maternal services

The proposal would remove detailed requirements for health-status determinations, developmental screening, follow-up, and assistance obtaining necessary care. Current §1302.41–§1302.46 establish a coordinated approach to family engagement, child health, screening, nutrition, mental health, and health education. General statutory obligations and the proposed focus on nutrition and physical education do not adequately replace the operational requirements that ensure concerns are identified and addressed.

A screening or referral has limited value if a family cannot obtain an appointment, secure transportation, understand the results, or complete treatment. Head Start staff help bridge those gaps. Weakening requirements for this work risks delayed identification and treatment of developmental, oral health, physical health, and mental health needs. It may also increase demands on Medicaid-financed care, CIS, IDEA Part C and B, primary care providers, designated mental health agencies, and other community partners; this will transfer costs to other state and federal funding sources and potentially force a reduction in services as budgets are depleted. We recommend that HHS evaluate these risks, including the potential for more intensive and costly services after preventive opportunities are missed.

Vermont's 2025 Health Services PIR reports that the number of children up to date on the state's preventive and primary care schedule increased from 717 at enrollment (59%) to 896 at the end of enrollment (74%). Children with continuous, accessible oral care increased from 710 (59%) to 872 (72%). At the end of enrollment, 1,162 children were enrolled in Medicaid and/or CHIP (96%). These descriptive changes show the relevance of health navigation and follow-up for a population largely covered by public insurance. Vermont recommends continuing requirements for timely screening, health-status review, referral, and documented follow-up; assistance connecting families with insurance and ongoing sources of care; and access to mental health consultation and coordinated supports. Programs should have flexibility to coordinate these activities with existing state and provider systems, with clear responsibility for ensuring completion.

We acknowledge that proposed §1301.04 and §1301.07 retain or add nutrition and physical activity provisions, including USDA meal requirements, holding bottle-fed infants, and appropriate breastmilk storage. Vermont supports attention to healthy food and physical activity which is why we already incorporate these requirements into our state child care licensing recommendations. We recommend that those provisions be accompanied by protections for individualized nutritional needs, special diets, responsive infant feeding, and sufficient meals and snacks for the length of the service day. The continued applicability of USDA rules may not



address every developmental or individualized service protection, a distinction that warrants consideration when evaluating the proposed removals.

Vermont's 2025 Health Services PIR identifies 332 children with a diagnosed chronic condition (27%), including 21 with life-threatening allergies. The 2025 Vermont Family Services PIR records nutrition education for 757 families (68% of families served), while 605 families received WIC and 658 received SNAP at enrollment. These data support the importance of individualized nutrition safeguards and continued coordination with WIC and 3SquaresVT/SNAP.

Proposed §1301.11 retains newborn visits and certain prenatal and postpartum education and referrals. However, the proposal removes the requirement to schedule a newborn visit within two weeks of birth, along with specific requirements to determine health care access, facilitate insurance coverage, reduce barriers to healthy maternal and birthing outcomes, and track services. The early postpartum period is a time when timely support matters. Without a defined timeframe and follow-up process, a visit and referral may not ensure that a family connects with care when it is most needed. Of the 49 pregnant women served in Vermont, nine had pregnancies identified as medically high risk (18%), and 20 received mental health interventions and follow-up while enrolled (41%). All 49 had health insurance by the end of enrollment, but only 45 had an ongoing source of continuous, accessible health care. This distinction illustrates why insurance coverage and a referral may need to be accompanied by assistance connecting with ongoing care. Vermont recommends retention of the two-week newborn-visit requirement, with narrowly justified flexibility for family circumstances, and continued requirements for maternal health navigation, individualized support, and follow-up. We recommend that HHS assess cost implications on maternal and infant health services, including MIECHV, IDEA Part C, and Medicaid, before removing these responsibilities from federally funded Early Head Start programs.

Disability inclusion, behavioral supports, and continuity of participation

Replacing the operational requirements of current Part 1302, Subpart F with the general compliance statement in proposed §1301.10 raises questions about how consistent implementation would be supported. IDEA and Head Start Act obligations would remain, but their continued existence does not establish that children will receive timely, coordinated support in daily program practice. Head Start needs clear responsibilities for individualized accommodations, participation in evaluation and planning, support while eligibility determinations are pending, and coordination with early intervention and special education providers. The scale of disability inclusion in Vermont is substantial: 191 of the 649 Head Start children had an IEP at some point during the year (29%), and 133 of the 563 Early Head Start children had an IFSP (24%). Programs also referred 127 children for an IDEA eligibility evaluation during the year; 80 received an evaluation, while 47 did not. The report identifies 20 children whose evaluations were pending and not yet completed by the responsible agency. These figures demonstrate the value of coordination and preserving individualized assistance while evaluations and service arrangements are underway.



CIS and LEAs are responsible for important services under IDEA, but those responsibilities do not substitute for Head Start's role in providing an inclusive early learning environment. Removing complementary Head Start requirements risks shifting more coordination and family assistance to already stretched state and school systems. Delays can leave children without appropriate support and make it harder to preserve developmental and educational gains. Vermont's collaboration strategy emphasizes interagency agreement and coordinated implementation precisely because children need partners to carry out distinct responsibilities together.

The proposed removal of current §1302.17, which limits suspension and prohibits expulsion because of a child's behavior, is especially concerning. Eliminating these federal protections would expose children to exclusion where state or local requirements do not provide equivalent protection. Applicable civil rights and disability laws remain important but should not be treated as a complete replacement for a clear Head Start standard that protects all enrolled children. Suspension or expulsion interrupts early learning, strains families' employment, and can force families to seek another placement in a system with limited capacity. Children whose behavior signals trauma, a disability, or unmet developmental or mental health needs should receive coordinated support. Excluding them can transfer the unresolved need to another provider or public system. Vermont programs reported that 125 of 203 classroom teachers, home visitors, and family child care providers received observation and consultation assistance from a mental health consultant (62%). This documents an existing support mechanism that is relevant to helping staff respond to children's needs and maintain participation.

We recommend that HHS retain the prohibition on behavioral expulsion and the existing limits and safeguards governing suspension. It should also retain requirements for mental health consultation, family partnership, individualized behavioral support, and coordination with IDEA partners. These provisions should be considered together: weakening support capacity while removing protection from exclusion compounds the risk to children.

Home-based services, family partnership, and parent participation

Removing the service duration and caseload requirements in current §1302.22, together with the home-based education requirements in §1302.35, would permit fewer or shorter visits, larger home-visitor caseloads, and less consistent group socialization and instructional support. The proposal does not mandate that every program make those reductions, but it removes enforceable minimums and uses reduced staffing and service requirements as a source of potential savings. Home-based services are a distinct early childhood intervention that supports parents in their role as children's first teachers. Relationships, regular contact, skilled observation, and follow-up are essential to its effectiveness. In rural Vermont, travel time and dispersed families further limit how many families a visitor can serve well. Larger caseloads cannot be assumed to produce equivalent services. We recommend that HHS retain minimum visit frequency and duration, group socialization requirements, manageable caseloads, and qualified supervision, while allowing justified adaptations for family needs and rural delivery. Vermont reported 209 funded



home-based slots, representing 20% of total funded enrollment, and 24 home visitors. These counts establish that the home-based option is a meaningful part of Vermont's service system.

The proposed removal of detailed family partnership requirements and family-service-worker caseload protections would also weaken the capacity to help families pursue their goals. Head Start staff connect families with housing, employment, health care, and public benefits, and coordinate with Reach Up/TANF, WIC, 3SquaresVT/SNAP, DCF Family Services/child welfare, Parent Child Centers, and housing and homelessness providers. These activities require sustained relationships and time to address barriers. A required family needs assessment without adequate staff capacity and follow-through cannot ensure meaningful assistance. Vermont's 2025 Family Services PIR identifies 246 families experiencing homelessness (22% of the 1,107 families served), of whom 103 acquired housing during enrollment (42%). Across all families, 422 received emergency or crisis intervention, 216 received housing assistance, and 987 received at least one of the family services listed in the PIR (89%). The figures only start to document the extent of family needs and services that could require additional support from other state and local systems if Head Start capacity decreases.

We recommend that HHS retain individualized family partnership processes, reasonable caseload protections, and accountable referral and follow-up responsibilities. It should also preserve accessible opportunities for parent participation at the local program level. Proposed §1301.01 makes parent committees optional; the statutory Policy Council remains required but serves a different governance function. Local parent participation should remain assured, with flexibility in how programs organize it. Family engagement should respect the circumstances and goals of each family, including single parents, kinship caregivers, and foster families.

Community planning transitions and workforce preparation

Removing the prescribed community-assessment framework in current §1302.11 and related data-use requirements would weaken the common basis for decisions about service areas, program options, hours, and priorities. Statutory community-assessment responsibilities would remain, but the proposal would eliminate important requirements for frequency, content, and updates. Vermont recommends retaining a regular assessment cycle and minimum information about eligible populations, unmet need, family schedules, disabilities, homelessness, and available services. Administrative simplification is appropriate where programs can use existing state or regional data rather than repeat collection. Head Start community assessments should connect with Vermont's planning through Building Bright Futures – Vermont's State Early Childhood Advisory Council, VT Agency of Human Services, Agency of Education, Department of Health, and other partners. A common information base helps identify rural gaps and supports responsible decisions about expansion or changes in program design. Eliminating the framework risks reducing responsiveness at the same time that programs would receive greater discretion over services.

The proposed rescission of current Part 1302, Subpart G would also remove detailed transition practices. Statutory obligations for coordination with schools and systematic Early Head Start transitions remain, but we recommend that HHS retain operational requirements that make those



obligations dependable. Families need advance planning, coordination with the receiving program or school, and transfer of relevant information with appropriate consent and confidentiality protections. Children with disabilities need continuity in accommodations and services during these transitions. Vermont's work to strengthen universal prekindergarten coordination and school transitions depends on Head Start as an active partner. Reduced transition capacity could leave families navigating preschool and kindergarten placement without adequate assistance and shift more work to LEAs. We recommend that HHS retain requirements for timely, individualized transitions and allow programs and state partners to use coordinated processes to avoid duplication. Vermont programs projected that 265 enrolled Head Start preschool children would enter kindergarten in the 2026 school year. The 2025 Family Services PIR records transition support for 409 families, including transitions from Early Head Start to Head Start and from Head Start to Kindergarten. These measures document the reach of transition planning and family assistance.

Vermont encourages careful consideration of how changes to workforce expectations would preserve demonstrated competence and continued professional development. The proposal removes detailed qualifications and professional development requirements in current §1302.91 and §1302.92. The effects extend beyond classroom teachers to home visitors, family services staff, and managers responsible for health and disability services. These roles require specific knowledge to identify concerns, support families, and coordinate complex services. Vermont reported 78 preschool classroom teachers, including 56 with a baccalaureate or advanced degree in the 2025 Staff Qualifications PIR (72%). Among 37 family services staff, 31 held a relevant credential, certification, or degree (84%). At the same time, 62 education and child development staff left during the year (24% of that staff group), and 15 vacancies remained unfilled for three months or longer. These figures support attention both to workforce preparation and to recruitment and retention. Vermont supports competency-based pathways, recognition of relevant experience, and accessible routes into the workforce. Such pathways should demonstrate the competencies required for high-quality practice and include supervised learning and ongoing professional development. They should not substitute an unspecified lower expectation for preparation. Vermont's own statewide early childhood strategic plan supports coordinated workforce development, including an infant and toddler credential, to strengthen service quality.

Rural implementation and considerations for further review

Small programs, dispersed populations, travel time, workforce availability, and limited alternative providers affect rural delivery. We recommend that HHS analyze these conditions specifically rather than assume that uniform reductions in staffing, hours, or administration will create usable capacity. It should also examine how changes interact: shorter hours, fewer family supports, and less transportation assistance may collectively make a nominally available slot inaccessible to the families Head Start is intended to serve.

Vermont encourages HHS to consider targeted revisions, informed by consultation with states, recipients, families, and service partners, that reduce administrative burden while preserving the comprehensive model. In considering a final rule, we recommend particular attention to



provisions that retain a workable administrative cost limit; protect eligibility and meaningful access; preserve enforceable standards for safety, health and developmental follow-up, disability inclusion, behavioral non-exclusion, maternal and infant support, and family partnership; and maintain adequate service duration and workforce competence.

Before finalizing changes, we recommend that HHS publish a revised analysis of intergovernmental fiscal and service impacts and allow meaningful public review. That analysis should reflect realistic scenarios for service transition, and thus cost shifting, to other state-funded programs as well as increased costs related to delayed screening and services for Head Start's population. Any implementation plan should provide sufficient time, technical assistance, and resources for changes in state and local coordination, with clear federal accountability for services that remain required. Vermont supports improvements that make Head Start easier to administer while preserving the comprehensive services children and families depend on. Additional analysis and revision to the proposed rule would help support that shared goal.

Respectfully,



Janet McLaughlin, Deputy Commissioner
Dept. for Children and Families, Child Development Division

