



Medicaid and Head Start:
Opportunities to Collaborate and Pay for Upstream Prevention





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INTRODUCTION

Significant potential for alignment of care coordination and service delivery exists between Head Start and Medicaid. This issue brief draws upon initial experiences from Maryland Medicaid’s early efforts to explore connecting one Medicaid managed care organization (MCO) with one or more local Head Start programs in the interest of linking families to needed services — including at least one upstream preventive service — and addressing the social determinants of health. Maryland Medicaid is meeting with a Medicaid MCO, Head Start representatives and a representative from the Maryland Academy of Nutrition and Dietetics to pilot the delivery of Medicaid-funded group nutritional counseling in Head Start settings.

Research has found that interventions in the areas of housing, income support, nutrition support, care coordination and community outreach have had positive effects in terms of health improvement or health care spending reductions.¹ Serving many of the same families, Head Start and Medicaid are natural partners to address social determinants of health and connect families to needed health services. This type of partnership could serve as a model and be developed in other states to explore braided funding approaches to support children’s optimal health and well-being.

HEAD START AND MEDICAID REQUIREMENTS: SHARED HEALTH GOALS

Head Start and Medicaid serve the same populations of children from birth to age five by virtue of income participation requirements. Head Start and Early Head Start serve children from families with incomes below the poverty line (100 percent of the federal poverty level).²

Although Medicaid eligibility policy varies greatly by state, all states must cover children through age five up to 133 percent of the federal poverty level.³ Head Start and Medicaid both serve additional special populations of children, such as those receiving Supplemental Security Income (SSI) and those in foster care.

As a public health insurance program that provides medical assistance to eligible individuals, Medicaid has traditionally focused solely on health care. However, given the influence of social determinants of health, state Medicaid programs have begun to look beyond medical care to address broader issues such as exposure and vulnerability to disease, risk-taking behaviors and unhealthy habits.⁴ Partnerships between Medicaid and social support-oriented organizations tend to be essential to these efforts.⁵

Although the goal of Head Start is to promote school readiness, its reach extends beyond the arena of education to support the comprehensive development of children. Under federal Head Start Program Performance Standards, health care is a core Head Start component.⁶ These new Head Start standards became effective in November 2016, which was the first major revamp of standards since 1975. The federal Head Start Program Performance Standards task Head Start with ensuring — through monitoring and tracking — that children have access to health insurance coverage and are receiving regular and ongoing preventive care and needed treatment.

The federal Head Start requirements allow for collaboration with Medicaid. For example, MCOs should already receive referrals from Head Start sites when children are identified as needing well-child, dental and other medical services. These referral mechanisms can be enhanced. Maryland evaluates its MCOs on their success in delivering recommended preventive care to children; scores are publicly reported, included in beneficiaries' enrollment materials, and tied to financial incentives.⁷ In addition to benefiting children and families, collaboration that leads to improved access has the potential to benefit MCOs in terms of financial incentives and market share.

Head Start and Medicaid each provide functions and services along a continuum to meet children's health needs. Via its charges to ensure children have access to health coverage, and that they receive preventive health care and treatment, Head Start connects children to health care. As such, Head Start helps to ensure early identification of health issues. Medicaid provides the medical home, and the broad Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit mandate entitles children to any treatment or procedure — within any category of Medicaid-covered services — to correct or ameliorate physical and mental illness or conditions.⁸

Nemours Children's Health System was awarded a one-year grant to help three state Medicaid programs test approaches to financing upstream prevention and population health through AcademyHealth's Payment Reform for Population Health initiative, with funding from the Robert Wood Johnson Foundation. While almost all states have begun Medicaid delivery system reform, initiatives and programs geared toward upstream prevention and population health are in varying stages of development. Nemours provided technical assistance to three states — Maryland, Oregon and Washington — as they developed or implemented upstream prevention strategies using Medicaid funds. This brief is one in a series of six "how to" briefs illustrating how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives. The entire series of briefs can be found at <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention>. To learn more about AcademyHealth's Payment Reform for Population Health initiative, visit www.academyhealth.org/p4ph.

Table 1 shows selected federal provisions from *Subpart D — Health Program Services — of Head Start Policy and Regulations, Part 1302 — Program Operations.*⁹

TABLE 1: Selected Health-Related Provisions of Federal Head Start Policy and Regulations

Federal Provision	Summary of Federal Requirements
Subpart D — Health Program Services	
1302.40 Purpose	<ul style="list-style-type: none"> Head Start must provide high-quality health, oral health, mental health and nutrition services.
1302.42 Child health status and care. (a) <i>Source of health care</i>	<ul style="list-style-type: none"> Within 30 days of enrollment, determine each child’s ongoing source of health care and health insurance coverage, and if needed, assist the family in accessing a source of care and health insurance as quickly as possible.
1302.42 Child health status and care. (b) <i>Ensuring up-to-date child health status</i>	<ul style="list-style-type: none"> Within 90 days of enrollment, obtain determinations from health care and oral health care professionals as to whether the child is up-to-date on preventive and primary medical and oral health care, based on the state Medicaid agency’s EPSDT schedule and recommendations from the local Health Services Advisory Committee based on prevalent community health problems. Assist parents with making arrangements to bring the child up-to-date as quickly as possible; and, if necessary, directly facilitate provision of health services to bring the child up-to-date. Within 45 days of enrollment, obtain or perform evidence-based vision and hearing screenings. Identify each child’s nutritional health needs, taking into account available health information, including the child’s health records, and family and staff concerns, including community nutrition issues.
1302.42 Child health status and care. (c) <i>Ongoing care</i>	<ul style="list-style-type: none"> Help parents continue to follow recommended schedules of well-child and oral health care. Implement periodic observations for program staff and parents to identify any new or recurring developmental, medical, oral or mental health concerns. Facilitate and monitor necessary oral health preventive care, treatment and follow-up.
1302.42 Child health status and care. (d) <i>Extended follow-up care</i>	<ul style="list-style-type: none"> Facilitate further diagnostic testing, evaluation, treatment and follow-up by a licensed or certified professional for each child with a health problem or developmental delay. Develop a system to track referrals and services provided, and monitor the implementation of a follow-up plan to meet any treatment needs associated with a health, oral health, developmental or social and emotional problem. Assist parents in obtaining any prescribed medications and health care aids or equipment.
1302.46 Family support services for health, nutrition, and mental health	<ul style="list-style-type: none"> Collaborate with parents to promote children’s health and well-being by providing medical, oral, nutrition and mental health education supports. Provide opportunities for parents to discuss their child’s nutritional status with staff, including the importance of physical activity, healthy eating, and the negative health consequences of sugar-sweetened beverages, and how to select and prepare nutritious foods that meet the family’s nutrition and food budget needs. Provide opportunities for parents to learn about healthy pregnancy and postpartum care, including breastfeeding support and treatment options for parental mental health or substance use disorders. Assist parents in navigating the health system to meet their children’s needs. Assist parents in understanding: how to access health insurance for themselves and their families; the results of diagnostic and treatment procedures; and plans for ongoing care.

Though virtually all children enrolled in Head Start are eligible for Medicaid, expenditures on direct health care services are allowable program costs in local Head Start program budgets.¹⁰ Federal Head Start guidance states that “[i]f the [Head Start] health manager has exhausted all possible funding sources, they are required as ‘payor of last resort’ to pay for costs.”¹¹ A federal Head Start budget template for local program health managers includes line items for fourteen categories of direct health services.¹² As such, Head Start programs may use funds from their budgets to pay for health care services that are covered by Medicaid. However, by ensuring that families and children obtain Medicaid-covered required health care services through Medicaid, Head Start programs can reallocate their budgets toward other components of their mandate to promote family well-being.



HEAD START EXPERTISE IN FAMILY ENGAGEMENT AND ASSESSMENT OF SOCIAL DETERMINANTS OF HEALTH

Head Start has been described as the “original two-generation model.”¹³ The two-generation philosophy addresses the needs of children and parents together. It recognizes the interconnection between healthy child development and families’ access to economic and social supports for stability, resilience and parenting skills. Guidance from the federal Office of Head Start states that “[w]hen families face challenges that cause stress, including poverty and homelessness, their health and wellness can be negatively impacted.”¹⁴ Head Start services — delivered in centers, child care partner locations and in children’s homes — include early learning, health and family well-being.¹⁵

Table 2 shows selected provisions from *Subpart E — Family and Community Engagement Program Services — Head Start Policy and Regulations, Part 1302 — Program Operations*.¹⁶ These provisions demonstrate Head Start’s focus on understanding the social determinants that can affect children’s health and well-being. Head Start engages parents through a family partnership process that identifies needs, interests, strengths, goals, and services and resources that support family well-being, including family safety, health and economic stability. The Head Start approach engages family members as partners in problem-solving and goal-setting, and provides support services that address housing and food assistance to support family members’ educational advancement and economic mobility.¹⁷ The Head Start Family Partnership Agreement Process (provision 1302.52) is one means of gathering information from families regarding strengths and needs.

The federal provisions in Table 2 also highlight the importance of collaborating with a variety of state and community agencies, including Medicaid. Likewise, some state Medicaid programs may encourage collaboration with programs such as Head Start. Maryland Medicaid regulations state that “[a]n MCO shall provide referrals for services not covered by Medicaid...including appropriate referrals to...[t]he Head Start Program.”¹⁸

TABLE 2: Selected Family and Community Engagement Provisions of Federal Head Start Policy and Regulations

Federal Provision	Summary of Federal Requirements
Subpart E— Family and Community Engagement Program Services	
1302.50 Family engagement. (a) Purpose.	<ul style="list-style-type: none"> Integrate parent/family engagement strategies into all services to support family well-being and promote children’s learning and development. Programs are encouraged to develop innovative two-generation approaches that address prevalent needs of families, leveraging community partnerships or other funding sources.
1302.50 Family engagement. (b) Family engagement approach.	<ul style="list-style-type: none"> Collaborate with families in a family partnership process that identifies needs, interests, strengths, goals and services and resources that support family well-being, including family safety, health and economic stability.
1302.52 Family partnership services. (a) Family partnership process.	<ul style="list-style-type: none"> Implement a family partnership process that includes a family partnership agreement. Initiate the process early and continue for as long as the family participates in the program, based on parent interest and need.
1302.52 Family partnership services. (b) Identification of family strengths and needs.	<ul style="list-style-type: none"> Implement intake and family assessment procedures to identify family strengths and needs related to the family engagement outcomes as described in the Head Start Parent Family and Community Engagement Framework.¹⁹
1302.52 Family partnership services. (d) Existing plans and community resources.	<ul style="list-style-type: none"> Take into consideration any existing plans for the family made with other community agencies and availability of other community resources to avoid duplication of effort.
1302.53 Community partnerships and coordination with other early childhood and education programs. (a) Community partnerships.	<ul style="list-style-type: none"> Establish ongoing collaborative relationships and partnerships with community organizations such as establishing joint agreements, procedures or contracts and arranging for onsite delivery of services as appropriate. Relationships/partnerships with community organizations may include health care providers, including child and adult mental health professionals, dentists, nutritional service providers and Medicaid managed care networks.

Nationally, many more children are enrolled in Medicaid than Head Start. There are approximately 10.8 million²⁰ children birth through age five in Medicaid versus 921,000 children in Head Start/Early Head Start.²¹ To determine enrollment prioritization, Head Start assesses an even broader population of children than those who ultimately receive a Head Start slot. This broader population of children is likely Medicaid eligible. Head Start intake workers (also referred to as enrollment administrators) conduct in-person comprehensive risk assessments with the parent and child, for example asking about housing stability, substance use, domestic violence, incarceration, language barriers or challenges, immigration challenges, food security and teen parenting. The more areas of risk identified, the higher the family’s score on the Head Start enrollment prioritization form. The Head Start selection process must consider the education, health, nutrition and social service needs of children and their families, “including prevalent social or economic factors that impact their well-being” and “resources that are available in the community to address the needs of eligible children and their families” (1302.11 Determining community strengths, needs and resources).²² The families with the highest risk score are offered enrollment slots. The risks families face and factors affecting their well-being are social determinants of health. Pursuing information-sharing mechanisms between Head Start(s) and Medicaid could be valuable for states to consider as they develop or enhance efforts to connect children to both needed health care and social services.

LEVERAGING EXISTING INFRASTRUCTURE TO ADDRESS FAMILIES' UPSTREAM NEEDS IN MARYLAND: OPPORTUNITIES AND KEY QUESTIONS

Maryland's initial exploration of Medicaid and Head Start collaboration identified opportunities to leverage Head Start infrastructure to scale up efforts to connect families to needed services, as well as to address families' upstream needs. The intensive case management systems within Head Start programs exist in parallel with, and may be complementary to, the infrastructure in place across Maryland's MCOs, which include case management and coordination for children with special health care needs.

While Maryland MCOs have robust case management programs for certain populations, not every MCO enrollee is assigned a MCO case manager, and not all case management includes a home-based option. In contrast, all Head Start enrollees are assigned a Head Start case manager to ensure children receive the range of health and social services they need. Head Start case management includes a home-based option that may be used to deliver services to a portion of a program's enrolled children.²³

According to federal requirements, every Head Start site has a "health coordinator" who focuses on issues related to health care, nutrition and disabilities. The health coordinator also helps to support and engage families as they identify their own health strengths and needs.²⁴ The role is intended to problem solve at the policy level, for example establishing partnerships with local provider associations and with state health departments. The health coordinator may also spend time helping to connect children with complex health needs to specialty health care services.

Increased MCO engagement with Head Start case management in general has the potential to leverage existing infrastructure and address upstream needs. Among the following opportunities identified, Maryland committed to pursuing the reimbursement of dietitians for group counseling in a Head Start setting.

Identify outreach and case management overlap opportunities between Medicaid and Head Start, and leverage knowledge and resources from both programs to optimize coordination and effectively meet families' needs. Parents have daily, sustained connections to their children's Head Start program, making it a setting well-suited to understand families' needs. For example, MCOs could receive incoming referrals from Head Start case managers regarding MCO members' service needs, such as children who need dental exams and treatment. Medicaid MCOs have the resources, expertise and responsibility to connect children to medically necessary health care services, and to pay for those services.²⁵ In some cases, MCOs already conduct health outreach and education at Head Start sites.

Gain information on the broader array of social determinants of health families face. Collaboration among Medicaid and Head Start programs can help tackle upstream social determinants of health, given the depth of information gathered through the Head Start intake and ongoing case management processes. Sharing information with the Medicaid medical home has the potential to help health care providers effectively meet families' needs. Information sharing is an important first step; a key question is how accountability is delineated between systems so that information becomes actionable. Each Head Start program has a Health Advisory Committee; likewise, each state Medicaid program has a Medicaid Advisory Committee. These groups can be allies in identifying and addressing community-level needs and developing pathways to services. They can each leverage their respective areas of expertise and networks to increase coordination and reduce duplication of services.



Engage vulnerable children and families to help them access preventive care and promote medical homes. Collaboration among the state Medicaid agency and MCOs with Head Start programs may provide an additional vehicle for Medicaid to engage vulnerable children and families and help them access needed preventive care such as well-child visits. This has potential benefits in helping MCOs meet quality performance standards for prevention, which has implications for MCO market share as well as value-based purchasing financial incentives.

Engage vulnerable children and families to help them access needed treatment. Engagement with Head Start programs may also provide a vehicle for Medicaid to connect children and families to needed treatment and specialty care, which could help improve the lives of children and families. Early identification enables health issues to be addressed before they require more complex and costly treatment. This supports Maryland Medicaid's goal of meeting enrollee needs in the primary care setting and decreasing potentially avoidable utilization of urgent care or emergency department services.



Maryland's early efforts to assess how to leverage existing infrastructure identified important questions for states and localities to consider when undertaking efforts to operationalize collaboration among Medicaid MCOs and Head Start. Because workflow practices can vary by Head Start program and by MCO within a state Medicaid program, it is important to explore these questions at a local level.

- How do Medicaid MCO and Head Start outreach and care coordination functions currently align or overlap?
- How is accountability for case managing a given health need delineated between the Medicaid MCO and Head Start case manager?
- How might Head Start tracking systems integrate with Medicaid MCO case management systems?
- How should the required parental consents for information sharing between systems be requested and documented?



OPPORTUNITIES TO BRAID FINANCING AND OPTIMIZE FUNDS FOR UPSTREAM PREVENTION

As with any initiative, funding is a key factor in moving Medicaid and Head Start collaboration forward. Despite the role of Medicaid in financing health care for children, across the nation some local Head Start programs provide health screenings and pay for them out of their own program budgets. A national survey of local Head Start programs found that nearly two-thirds provided vision and hearing screenings, and more than half reported paying for the screenings from Head Start program budgets to meet federal Head Start Program Performance Standards. Similarly, more than 80 percent of responding programs conduct behavioral and developmental screenings, with more than 70 percent reporting paying for the screenings out of Head Start program budgets.²⁶

Maryland's initial efforts highlighted the following four strategies for leveraging existing financing streams to better address upstream needs and social determinants of health, and for ensuring the most appropriate payor of services.

(1) Aim for a financing approach to support children's optimal health and well-being.

Children enrolled in both Medicaid and Head Start receive services from both programs. Tapping into the relative expertise and efficiencies of both Head Start and Medicaid can help ensure that the variety of available services are brought to bear to improve child well-being, and can increase the efficiency of serving these children and their families. When Head Start programs ensure their families and children obtain Medicaid-covered required health care services through Medicaid, they may be able to reallocate budgets toward other components of their mandate. For example, they could work to promote family well-being, including efforts to address housing and neighborhood safety, food security, financial stability and child abuse and domestic violence. It is within Head Start's mandate to address these needs; in contrast, state Medicaid agencies and Medicaid MCOs face federal regulatory barriers to covering them.

There are two primary means to leveraging Medicaid and Head Start expertise and funds: ensuring EPSDT services are billed to Medicaid; and reducing administrative and clinical duplication, if it exists.

(2) Ensure that Medicaid-covered services are paid for by Medicaid.

As reported in the National Head Start Association survey, *Health in Head Start: Expanding Access and Improving Quality*,²⁷ when Head Start programs do not connect children to Medicaid services, the Head Start program pays for health care services in order to meet federal performance standards. Health care services are covered by Medicaid, and therefore do not have to be financed via Head Start program funds. For instance, Maryland is piloting how the Medicaid-covered benefit of group nutritional counseling for obesity prevention and treatment may be offered in the Head Start setting, and reimbursed by Medicaid. Ideally, children should access the range of required preventive screenings, as well as any resulting additional services needed (as recommended by the provider on an individual basis) in connection with their medical home. A child's regular provider has a comprehensive understanding of his or her well-being. States and jurisdictions with Head Start programs that provide or contract for direct health care services could explore billing Medicaid and sharing screening results with the child's medical home. This is consistent with National Head Start Association recommendations to strengthen Head Start and Medicaid collaboration so that Head Start programs can enroll as Medicaid providers and bill for services directly, or contract with Medicaid providers in their communities.²⁸

(3) Reduce duplication of administrative functions as well as clinical services.

Families have frequent interaction with their children's Head Start programs; Medicaid has expertise in leveraging comprehensive health care networks. States could explore bridging existing Medicaid and Head Start case management infrastructure. Doing so could enable Medicaid programs to connect children to needed health care services — paid for by Medicaid — while eliminating duplication of case management efforts. As noted above, a key question is delineating accountability between the Medicaid MCO and the Head Start program for case managing a given health need. For example, a process could be in place by which a Head Start case manager refers a child to the MCO for help identifying a specialty health care provider. This would free up time for the Head Start case manager to focus on the child and family's upstream needs. Closing communication gaps between Medicaid and Head Start also has the potential to reduce duplication of clinical services by ensuring that results of screenings conducted by pediatricians are shared with the Head Start program so the screenings are not repeated.

(4) Identify the remaining needs for which a payment mechanism does not exist.

Greater collaboration among Medicaid and Head Start programs can help highlight families' unmet social determinants of health needs for which payment mechanisms — through Medicaid, Head Start or other funding sources — do not exist. For example, collaboration between the State Medicaid Advisory Committee and the local Head Start Health Advisory Committee can identify priority needs of families that are not met by either system, such as having an adequate supply of affordable housing. This information can flow up to help prioritize future efforts to address upstream needs by the public and private sectors at the local, regional and state levels.

CONCLUSION

Maryland’s early efforts to connect one Medicaid MCO with a local Head Start program identified several themes. Medicaid and Head Start serve the same children and have different strengths and expertise that can advance shared goals. Head Start programs have strong levels of engagement with families and children, and are required to monitor and track children’s access to health care. Medicaid has the comprehensive health care networks — and funding mechanisms — needed to meet children’s health needs. Collaboration with Head Start to connect children and families to care has the potential to help MCOs meet performance standards. Ensuring that children and families receive Medicaid-covered required health services from Medicaid may enable Head Start budgets to be allocated for other needs, which may include addressing additional social determinants of health, and allow Head Start to serve more children and families.

Maryland undertook planning for its pilot in an aggressive timeframe, and current steps are bringing together state Medicaid leadership, local Head Start leadership, an MCO and a key health care provider association. As the state moves towards operationalizing the pilot to provide Medicaid-funded group nutritional counseling services within Head Start settings, it is on a path to uncover ways that Medicaid and Head Start collaboration can achieve Head Start mandates and EPSDT’s stated goal of delivering the right care to the right child at the right time in the right setting by engaging families on a broad range of issues that support well-being.

REFERENCES

1. Taylor L.A., Tan A.X., Coyle C.E., et al. Leveraging the social determinants of health: what works? PLoS One. 2016;11(8):e0160217. DOI: 10.1371/journal.pone.0160217. Available at: <https://sirenetwork.ucsf.edu/tools-resources/resources/leveraging-social-determinants-health-what-works>
2. Head Start Early Childhood Learning & Knowledge Center. *Poverty Guidelines and Determining Eligibility for Participation in Head Start Programs*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/eligibility-ersea/article/poverty-guidelines-determining-eligibility-participation-head-start>
3. Medicaid and CHIP Payment and Access Commission. *Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State*. Washington, DC: January 2017. Available at: <https://www.macpac.gov/publication/medicaid-and-chip-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-women-by-state/>
4. Medicaid and CHIP Payment and Access Commission. *Report to the Congress on Medicaid and CHIP, Chapter 3*. Washington, DC: June 2014. Available at: https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_and_Population_Health.pdf
5. Ibid.
6. Head Start Early Childhood Learning & Knowledge Center. *Subchapter B-The Administration for Children and Families, Head Start Program*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii>
7. Maryland Department of Health. *HealthChoice Quality Assurance Quality Strategy*. Annapolis, MD. Available at: <https://mmcp.health.maryland.gov/healthchoice/pages/HealthChoice-Quality-Assurance-Activities.aspx>
8. CMS. *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. June 2014. Available at: https://www.medicare.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf
9. Head Start Early Childhood Learning & Knowledge Center. *Part 1302-Program Operations*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/policy/45->

cfr-chap-xiii/part-1302-program-operations

10. Ibid.
11. Head Start Early Childhood Learning & Knowledge Center. *Health Manager's Orientation Guide, Chapter 4*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/hmog-chapter-4.pdf>
12. Head Start Early Childhood Learning & Knowledge Center. *Sample Health Component Budget Format in Appendices to Health Manager Orientation Guide Module*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/hmog-appendices.pdf>
13. National Head Start Association. *Health in Head Start*. 2017.
14. Head Start Early Childhood Learning & Knowledge Center. *Family Support and Well-being*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/family-support-well-being>
15. Office of Head Start. *About the Office of Head Start*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://www.acf.hhs.gov/ohs/about>
16. Head Start Early Childhood Learning & Knowledge Center. *Part 1302-Program Operations*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/part-1302-program-operations>
17. Office of Head Start. *About the Office of Head Start*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://www.acf.hhs.gov/ohs/about>
18. COMAR 10.09.67.20.C. from <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.67.20.htm>
19. Head Start Early Childhood Learning & Knowledge Center. *PFCE Interactive Framework*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/school-readiness/article/pfce-interactive-framework>
20. Estimate based on the following sources: 23.9 million children ages 0 through 5 in the U.S. in 2014, from https://www.childtrends.org/wp-content/uploads/2015/12/53_Number_of_Children.pdf. 45% of children under the age of six are enrolled in Medicaid and CHIP. From <https://ccf.georgetown.edu/wp-content/uploads/2017/02/MedicaidYoungChildren.pdf>
21. National Head Start Association. *Head Start by the Numbers Fact Sheet* (total funded slots 2015-16). Available at: <https://www.nhsa.org/facts>
22. Head Start Early Childhood Learning & Knowledge Center. 1302.11 *Determining community strengths, needs, and resources*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-11-determining-community-strengths-needs-resources>
23. Head Start Early Childhood Learning & Knowledge Center. 1302.22 *Home-based option*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-22-home-based-option>
24. Head Start Early Childhood Learning & Knowledge Center. *Health Manager's Orientation Guide, Chapter 4*. Washington, DC: Administration for Children and Families, U.S. Department of Health & Human Services. Available at: <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/hmog-chapter-4.pdf>
25. In the Maryland Medicaid program some services, such as behavioral health care, are carved out of the MCO benefit package and paid for directly by the State Medicaid agency.
26. National Head Start Association. *Health in Head Start*. February 2017.
27. Ibid.
28. Ibid.



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