UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS and LUBBOCK INDEPENDENT SCHOOL DISTRICT, *Plaintiff*,	§	
v.	§	
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOOYUEN CHANG, in her official capacity as Principal Deputy Assistant Secretary; ADMINISTRATION FOR CHILDREN AND FAMILIES; KATIE HAMM, in her official capacity as Deputy Assistant Secretary for Early Childhood Development; OFFICE OF EARLY CHILDHOOD DEVELOPMENT; BERNADINE FUTRELL, in her official capacity as Director of the Office of Head Start; OFFICE OF HEAD START; and JOSEPH R. BIDEN, in his official capacity as President of the United States, *Defendants.*	§	**CIVIL ACTION NO. 5:21-CV-300**

ORIGINAL COMPLAINT

I. INTRODUCTION

1. Plaintiffs bring this action to challenge Defendants' Interim Final Rule with Comment, 86 Fed. Reg. 68,052 (November 30, 2021), entitled "Vaccine and Mask Requirements To Mitigate

the Spread of COVID-19 in Head Start Programs" (hereinafter "Interim Final Rule") (attached as Exhibit 1).

2. The Interim Final Rule imposes an unprecedented Vaccine Mandate on Head Start staff, volunteers, and contractors throughout the nation. It also imposes an unprecedented Mask Mandate on children two years of age and older who attend Head Start, as well as any individual in a Head Start facility—such as parents picking up or dropping off their children.

A. The Head Start Program

3. Head Start is a federal grant program that provides funding to school districts, nonprofits, and other community educational providers. Head Start programs promote the school readiness of infants, toddlers, and preschool-aged children from low-income families. Head Start Programs, Office of Head Start (Nov. 3, 2020), https://www.acf.hhs.gov/ohs/about/head-start.

4. Head Start programs are available at no cost to children ages birth to 5 from low-income families. *Id.* Families and children experiencing homelessness, and children in the foster care system are also eligible. *Id.* Preschool students whose attendance is funded via Head Start grant funding are often in preschool classrooms with other students whose attendance is funded by either state funds, district funds, or parent tuition. *See* Declaration of Lubbock ISD Superintendent Dr. Kathy Rollo, attached as Exhibit 3.

5. Head Start programs deliver services through 1,600 agencies in local communities, and provide services to more than a million children every year, in every U.S. state and territory. *Id.*

6. The purpose of Head Start is to "promote the school readiness of low-income children by enhancing their cognitive, social, and emotional development—(1) in a learning environment that supports children's growth in language, literacy, mathematics, science, social and emotional

functioning, creative arts, physical skills, and approaches to learning; and (2) through the provision to low-income children and their families of health, educational, nutritional, social, and other services that are determined, based on family needs assessments, to be necessary." 42 U.S.C. § 9831.

7. The Office of Head Start provides grants to Head Start agencies in Texas and throughout the country. Head Start programs are operated by several types of entities, including independent school districts. Staff employed by Head Start programs are not federal employees.

8. According to the United States Department of Health and Human Services' Tracking Accountability in Government Grants System website, HHS awarded a total of $842,280,184 in grants to Texas Head Start programs in fiscal year 2021. Exhibit 2.

B. The Head Start Interim Final Rule

9. On November 30, 2021, after months of choosing to encourage Head Start employees and volunteers to receive the COVID-19 vaccination, Defendants, at the direction of President Biden, moved the goalposts and issued the Interim Final Rule, which contains a Vaccine Mandate and Mask Mandate.[1]

10. The Vaccine Mandate forces local Head Start programs, including the programs operated by Texas Tech University and the Lubbock Independent School District ("LISD"), to choose between either cancelling the program or forcing their staff, contractors, and volunteers to comply

[1] *See*, *e.g.*, "Tips for Talking to Head Start Families and Staff About the COVID-19 Vaccines" (dated March 24, 2021), https://eclkc.ohs.acf.hhs.gov/publication/tips-talking-head-start-families-staff-about-covid-19-vaccines.

with an illegal federal mandate that violates their constitutional rights, while dealing with the inevitable fallout from the resulting resignations that will damage the program.[2]

11. The Mask Mandate forces Americans with children in Head Start to choose between complying with the illegal mandate and allowing staff to force their children to wear masks, or withdrawing their children from the program. As Defendants admit, enforcing the Mask Mandate on toddlers will require frequent staff physical intervention: "It should be noted that like all new skills, children will need to be taught the proper way to put a mask on and keep a mask on. While children are adaptable, they are still in the early stages of development and may need reminders and reinforcements to comply with this new practice." 86 Fed. Reg. at 68,060. Time spent reminding and reinforcing toddlers to wear masks is time away from enhancing their cognitive, social, and emotional development— to say nothing of the detrimental effect mask wearing has on that very cognitive, social, and emotional development. Presumably, head start programs will have to discharge toddlers who are unable or unwilling to comply with the Mask Mandate from the program or risk their continued receipt of Head Start financial assistance.

[2] Declaration of Lubbock ISD Superintendent Dr. Kathy Rollo, attached as Exhibit 3 ("If LISD complies with these new requirements, it has the potential for a mass exodus of Pre K staff."); Declaration of Vice Chancellor and General Counsel of the Texas Tech University System, Eric Bentley, attached as Exhibit 4 ("Staff must be fully vaccinated by January 2022 to remain employed with the Head Start program."); *see also* Elisabeth Waldon, *'What is on your radar?' Gov. Whitmer meets with Howard City leaders to hear their thoughts, concerns*, The Daily News, Dec. 7, 2021, https://www.thedailynews.cc/articles/what-is-on-your-radar/ (Michigan Governor Gretchen Whitmer stating her opposition to vaccine mandates because "I know that if that mandate happens, we're going to lose state employees. That's why I haven't proposed a mandate at the state level. Some states have. We have not, we're waiting to see what happens in court"); Andrea Johnson, *Head Start must close classrooms, fire staff due to federal COVID-19 vaccine mandate*, Minot Daily News, Dec. 10, 2021, https://www.minotdailynews.com/news/local-news/2021/12/head-start-must-close-classrooms-fire-staff-due-to-federal-covid-19-vaccine-mandate/.

12. Moreover, the Mask Mandate requires *anyone* at a Head Start program—including parents visiting, dropping their children off, or picking them up—to wear masks.

13. The Vaccine Mandate applies even if an individual has natural immunity.

14. The Mask Mandates applies even if an individual has natural immunity or is vaccinated.

C. The Biden Administration's Infringement on State Rights

15. The State of Texas and the LISD have sought to protect individual rights while also encouraging and promoting effective public health techniques to combat the spread of COVID-19. Disregarding Texas's plan to stop the spread of COVID-19, the federal government, however, has launched a coordinated effort to decide for itself whether and when Americans must receive the vaccine.

16. Instead of deferring to the States' expertise to address the specifics of their state needs and unique populations, President Biden has chosen to unlawfully take matters into his own hands. In fact, after months of saying the federal government could not mandate vaccines, President Biden announced that his "patience was wearing thin" with Americans who choose not to receive the COVID-19 vaccine.[3] He even went so far as to single out Texas as an obstacle to be removed because of its stance in favor of individual liberty. Speaking about Texas Governor, Greg Abbott, President Biden threatened that "[i]f they'll not help—if these governors won't help us beat the

[3] Joseph Biden, Remarks by President Biden on Fighting the Covid-19 Pandemic (Sept. 9, 2021), https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/09/remarks-by-president-biden-on-fighting-the-covid-19-pandemic-3/.

pandemic, I'll use my power as President to get them out of the way."[4] And yet, then-President-Elect Biden previously vowed not to demand any mandatory vaccinations.[5]

17. Our Constitution provides for a federal government of limited powers. The Constitution does not grant the federal government general police powers to dictate every facet of its citizens' lives. Defendants' disregard for the limits that the Constitution and federal statutes impose is nothing short of a dramatic infringement upon individual liberties, principles of federalism and separation of powers, and the rule of law.

D. The Interim Final Rule is Irrational

18. The decision to mandate vaccinations for all Head Start staff, contractors, and volunteers, and masks for all Head Start staff, contractors, volunteers, and children was uninformed, illogical, and without statutory authority. Congress never authorized Defendants (under the guise of promulgating "program performance standards") to mandate vaccinations for Head Start staff, contractors, and volunteers or masking for children, their parents, staff, contractors, and volunteers.

19. In their rush to push out the Vaccine Mandate and the Mask Mandate, and notwithstanding its lack of statutory authority, Defendants failed to follow the statutorily mandated notice-and-comment rulemaking procedures.

20. In contrast to mandating vaccinations for Head Start staff and masks for children attending Head Start, the President has made no effort to mandate vaccinations or masking in our nation's

[4] *Id.*
[5] Jacob Jarvis, *Fact Check: Did Joe Biden Reject Idea of Mandatory Vaccines in December 2020?*, Newsweek, Sept. 10, 2021, https://www.newsweek.com/fact-check-joe-biden-no-vaccines-mandatory-december-2020-1627774.

K through 12 schools, even though he claims, "We know how to keep students safe in schools by taking the right steps to prevent transmission—including getting all staff and eligible students vaccinated, implementing universal indoor masking, maintaining physical distancing, improving ventilation, and performing regular screening testing for students and school staff."[6] Instead, he passes the buck and tepidly "calls for Governors to require vaccinations for teachers and school staff."[7] Under the Interim Final Rule, governors do not have the same option for Head Start staff in their states.

21. President Biden does not even enforce his own vaccine mandate for federal employees. The mandate required all federal employees—even those who work from home—to be vaccinated by November 22, 2021. After that date passed, the federal government "updated" its "mandate" and allowed federal employees an unspecified additional amount of time to "demonstrate progress towards becoming vaccinated." And added an additional out by providing that the "Operational needs of agencies and the circumstances affecting a particular employee may warrant departure from these guidelines if necessary."[8] Thus, the federal government does not enforce its vaccine mandate against its own employees, yet demands that Head Start staff, contractors, and volunteers, who are not federal employees, be vaccinated or face termination. This is arbitrary and capricious.

E. The Biden Administration's Other Attempts to Mandate Vaccines have Failed

22. Defendants' Head Start mandate is one of several mandates President Biden has attempted to impose on many Americans (but not federal employees). Defendants call these mandates

[6] https://www.whitehouse.gov/covidplan/ (last visited Dec. 5, 2021).
[7] *Id.*
[8] https://www.saferfederalworkforce.gov/faq/vaccinations/ (last visited Dec. 5, 2021).

"elements of a national strategy to combat COVID-19." 86 Fed. Reg. at 68,069. Other "elements" are OSHA's vaccine mandate to employers with 100 or more employees, CMS's vaccine mandate for workers in most health care settings that receive Medicare or Medicaid reimbursement, and the vaccine mandate for federal contractors. Federal courts have stayed all three of these other "elements" as exceeding statutory authority (and should stay the Head Start mandate too).

23. Even one American being forced by their government to receive a vaccine that they do not want out of fear of losing their job is an irreparable injury and a stain on Defendants' records. But the broader implications of these unlawful vaccine mandates, if they are not stopped, portend a dark future for the economy and the American way of life.

24. Defendants' Vaccine Mandate and Mask Mandate for Head Start is unlawful, and Defendants should be enjoined from implementing it.

II. PARTIES

25. Plaintiff the State of Texas is a sovereign State of the United States and brings this suit to vindicate its sovereign and quasi-sovereign interests and on behalf of its citizens *parens patriae*.

26. Plaintiff Lubbock Independent School District ("LISD" or "the District") is a public school district operating in Lubbock County, Texas. LISD is a political subdivision and derives its legal status from Article VII of the Constitution of the State of Texas and from the Texas Education Code as passed and amended by the Legislature of Texas. LISD offers a full range of educational opportunities to public school students and their families in Lubbock County and operates a Head Start program within its preschool offerings. LISD has requested the Attorney General of Texas to represent it in this matter by adopting a Board Resolution to that effect in its December 9, 2021 meeting. *See* Tex. Educ. Code § 11.151(e).

27. Defendant Xavier Becerra is Secretary of HHS. He is sued in his official capacity.

28. Defendant United States Department of Health and Human Services (HHS) is a cabinet-level executive branch department of the United States.

29. Defendant JooYuen Chang is the Principal Deputy Assistant Secretary of the Administration for Children and Families. She is sued in her official capacity.

30. Defendant the Administration for Children and Families is a Division of HHS.

31. Defendant Katie Hamm is Deputy Assistant Secretary for Early Childhood Development, Office of Early Childhood Development. She is sued in her official capacity.

32. Defendant the Office of Early Childhood Development is an office of the Administration for Children and Families.

33. Defendant Bernadine Futrell is the Director of the Office of Head Start. She is sued in her official capacity.

34. Defendant Office of Head Start is an office of the Office of Early Childhood Development, and is the office within HHS responsible for the Head Start program.

35. Defendant Joseph R. Biden is President of the United States. He is sued in his official capacity.

III. JURISDICTION AND VENUE

36. This Court has jurisdiction under 5 U.S.C. §§ 702 and 703 and 28 U.S.C. §§ 1331, 1346, and 1361, under the United States Constitution, and pursuant to the Court's equitable powers.

37. The Court is authorized to award the requested declaratory and injunctive relief under 5 U.S.C. §§ 702 and 706 and 28 U.S.C. §§ 1361, 2201, and 2202.

38. Venue is proper within this District under 28 U.S.C. § 1391(c)(2).

IV. LEGAL BACKGROUND

A. Statutes

39. Defendants assert that the Interim Final Rule is authorized "under the authority granted to the Secretary by … 42 U.S.C. 9836a(a)(1)(C)–(E)), (D) and (,) [sic]," 86 Fed. Reg. at 68,052, which it also refers to as "42 U.S.C. 9836a§ 9836a(a)(1)(C),(D), (E) [sic]." 86 Fed. Reg. at 68,053. Plaintiff assumes that the asserted statutory authority is 42 U.S.C. § 9836a(a)(1)(C), (D) and (E).

40. But Defendants have never before claimed that these sections authorize the federal government to interpose itself between Head Start staff and their health care decisions, much less to mandate vaccination for all Head Start employees. Nor have Defendants ever claimed that those sections authorize it to direct children who attend Head Start to wear a mask or perform any similar actions in the name of health.

41. That is for good reason: Congress has never supplied the Secretary with such sweeping authority. 42 U.S.C. § 9836a(a)(1)(C), (D), and (E) reads:

> **(a) Standards**
>
> **(1) Content of standards**
>
> The Secretary shall modify, as necessary, program performance standards by regulation applicable to Head Start agencies and programs under this subchapter, including—
>
> **(C)** administrative and financial management standards;
>
> **(D)** standards relating to the condition and location of facilities (including indoor air quality assessment standards, where appropriate) for such agencies, and programs, including regulations that require that the facilities used by Head Start agencies (including Early Head Start

agencies and any delegate agencies) for regularly scheduled center-based and combination program option classroom activities—

(i) shall meet or exceed State and local requirements concerning licensing for such facilities; and

(ii) shall be accessible by State and local authorities for purposes of monitoring and ensuring compliance, unless State or local laws prohibit such access; and

(E) such other standards as the Secretary finds to be appropriate.

42. If a Head Start program fails to meet statutory or regulatory standards, the Secretary of HHS shall require the program to correct the deficiency within 90 days, or immediately if the Secretary finds that the deficiency threatens the health or safety of staff or program participants, and to initiate proceedings to terminate program unless the it corrects the deficiency. 42 U.S.C. § 9836a(e).

43. 42 U.S.C. § 9836a(a)(2) places limitations on how HHS may modify program performance standards. It reads:

(2) Considerations regarding standards

In developing any modifications to standards required under paragraph (1), the Secretary shall—

(A) consult with experts in the fields of child development, early childhood education, child health care, family services (including linguistically and culturally appropriate services to non-English speaking children and their families), administration, and financial management, and with persons with experience in the operation of Head Start programs;

(B) take into consideration—

(i) past experience with use of the standards in effect under this subchapter on December 12, 2007;

(ii) changes over the period since October 27, 1998, in the circumstances and problems typically facing children and families served by Head Start agencies;

(iii) recommendations from the study on Developmental Outcomes and Assessments for Young Children by the National Academy of Sciences, consistent with section 9844(j) of this title;

(iv) developments concerning research-based practices with respect to early childhood education and development, children with disabilities, homeless children, children in foster care, and family services, and best practices with respect to program administration and financial management;

(v) projected needs of an expanding Head Start program;

(vi) guidelines and standards that promote child health services and physical development, including participation in outdoor activity that supports children's motor development and overall health and nutrition;

(vii) changes in the characteristics of the population of children who are eligible to participate in Head Start programs, including country of origin, language background, and family structure of such children, and changes in the population and number of such children who are in foster care or are homeless children;

(viii) mechanisms to ensure that children participating in Head Start programs make a successful transition to the schools that the children will be attending;

(ix) the need for Head Start agencies to maintain regular communications with parents, including conducting periodic meetings to discuss the progress of individual children in Head Start programs; and

(x) the unique challenges faced by individual programs, including those programs that are seasonal or short term and those programs that serve rural populations;

(C)

(i) review and revise as necessary the standards in effect under this subsection; and

(ii) ensure that any such revisions in the standards will not result in the elimination of or any reduction in quality, scope, or types of health, educational, parental involvement, nutritional, social, or

other services required to be provided under such standards as in effect on December 12, 2007; and

(D) consult with Indian tribes, including Alaska Natives, experts in Indian, including Alaska Native, early childhood education and development, linguists, and the National Indian Head Start Directors Association on the review and promulgation of standards under paragraph (1) (including standards for language acquisition and school readiness).

B. Regulations

44. Before November 30, 2021, Head Start rules (45 C.F.R. § 1302.93) governed staff health only to the following limited extent:

§ 1302.93 Staff health and wellness.

(a) A program must ensure each staff member has an initial health examination and a periodic re-examination as recommended by their health care provider in accordance with state, tribal, or local requirements, that include screeners or tests for communicable diseases, as appropriate. The program must ensure staff do not, because of communicable diseases, pose a significant risk to the health or safety of others in the program that cannot be eliminated or reduced by reasonable accommodation, in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(b) A program must make mental health and wellness information available to staff regarding health issues that may affect their job performance, and must provide regularly scheduled opportunities to learn about mental health, wellness, and health education.

45. The Interim Final Rule adds paragraphs (a)(1) and (2):

(1) All staff, and those contractors whose activities involve contact with or providing direct services to children and families, must be fully vaccinated for COVID-19, other than those employees:

(i) For whom a vaccine is medically contraindicated;

(ii) For whom medical necessity requires a delay in vaccination; or

(iii) Who are legally entitled to an accommodation with regard to the COVID-19 vaccination requirements based on an applicable Federal law.

> **(2)** Those granted an accommodation outlined in paragraph (a)(1) of this section must undergo SARS-COV-2 testing for current infection at least weekly with those who have negative test results to remain in the classroom or working directly with children. Those with positive test results must be immediately excluded from the facility, so they are away from children and staff until they are determined to no longer be infectious.

86 Fed. Reg. at 68,101.

46. The new paragraphs require staff and contractors to be vaccinated, and to get tested weekly if granted an accommodation against being vaccinated. No such requirement existed in the prior version.

47. Before November 30, 2021, Head Start rules (45 C.F.R. § 1302.94(a)) governed volunteer health only to the following limited extent:

> **(a)** A program must ensure regular volunteers have been screened for appropriate communicable diseases in accordance with state, tribal or local laws. In the absence of state, tribal or local law, the Health Services Advisory Committee must be consulted regarding the need for such screenings.

48. But now the Interim Final Rule revises paragraph (a) to read as follows:

> **(a)** A program must ensure volunteers have been screened for appropriate communicable diseases in accordance with state, tribal or local laws. In the absence of state, tribal, or local law, the Health Services Advisory Committee must be consulted regarding the need for such screenings.
>
> **(1)** All volunteers in classrooms or working directly with children other than their own must be fully vaccinated for COVID-19, other than those volunteers:
>
> **(i)** For whom a vaccine is medically contraindicated;
>
> **(ii)** For whom medical necessity requires a delay in vaccination; or
>
> **(iii)** Who are legally entitled to an accommodation with regard to the COVID-19 vaccination requirements based on an applicable Federal law.
>
> **(2)** Those granted an accommodation outlined in paragraph (a)(1) of this section must undergo SARS-CoV-2 testing for current infection at least weekly with those who have negative test results to remain in the classroom or work directly with children. Those with positive test results must be immediately excluded

> from the facility, so they are away from children and staff until they are determined to no longer be infectious.

86 Fed. Reg. at 68,101.

49. The new paragraphs require volunteers to be vaccinated, and to get tested weekly if granted an accommodation against being vaccinated. No such requirement existed in the prior version.

50. Before November 30, 2021, Head Start rules (45 C.F.R. § 1302.47(b)(5)) governed child safety only to the following limited extent:

> **(5)** Safety practices. All staff and consultants follow appropriate practices to keep children safe during all activities, including, at a minimum:
>
> **(i)** Reporting of suspected or known child abuse and neglect, including that staff comply with applicable federal, state, local, and tribal laws;
>
> **(ii)** Safe sleep practices, including ensuring that all sleeping arrangements for children under 18 months of age use firm mattresses or cots, as appropriate, and for children under 12 months, soft bedding materials or toys must not be used;
>
> **(iii)** Appropriate indoor and outdoor supervision of children at all times;
>
> **(iv)** Only releasing children to an authorized adult, and;
>
> **(v)** All standards of conduct described in § 1302.90(c).[9]

51. The Interim Final Rule adds paragraph (b)(5)(vi) to read as follows:

> **(vi)** Masking, using masks recommended by CDC, for all individuals 2 years of age or older when there are two or more individuals in a vehicle owned, leased, or arranged by the Head Start program; indoors in a setting when Head Start services are provided; and for those not fully vaccinated, outdoors in crowded settings or during activities that involve sustained close contact with other people, except:
>
> **(A)** Children or adults when they are either eating or drinking;

[9] 45 C.F.R. § 1302.90(c) requires staff, consultants, contractors, and volunteers to address appropriate implement positive strategies to support children's well-being and prevent and address challenging behavior and to not maltreat or endanger the health or safety of children.

> **(B)** Children when they are napping;
>
> **(C)** When a person cannot wear a mask, or cannot safely wear a mask, because of a disability as defined by the Americans with Disabilities Act; or
>
> **(D)** When a child's health care provider advises an alternative face covering to accommodate the child's special health care needs.

86 Fed. Reg. at 68,101.

52. The new paragraph requires masking. No such requirement existed in the prior version.

53. Paragraph (vi) applies to all "individuals 2 years of age or older" who are "indoors in a setting when Head Start services are provided" and "outdoors in crowded settings or during activities that involve sustained close contact with other people" According to the Interim Final Rule, "The Office of Head Start notes that being outdoors with children inherently includes sustained close contact for the purposes of caring for and supervising children." 86 Fed. Reg. at 68,060. Thus, the Mask Mandate appears to also apply to parents who enter a Head Start facility (either when dropping off or picking up their child or at any other time) and to parents are outside with their children (either when dropping them off, picking them up, or at any other time), since being outside with children "inherently includes sustained close contact."

V. FACTUAL BACKGROUND

A. The Biden Administration Response to COVID-19.

54. As Defendants acknowledge, the Administration for Children and Families "initially chose, among other actions, to allow Head Start programs to decide whether or not to require staff vaccination rather than require vaccination." 86 Fed. Reg. at 68,054.

55. Similarly, before September 2021, the President's consistent position had been that the federal government lacks the authority Defendants are now claiming to possess. For example, on

July 23, 2021, the White House acknowledged that imposing vaccine mandates is "not the role of the federal government; that is the role that institutions, private-sector entities, and others may take …. [W]e're going to continue to work in partnership to fight misinformation. And we're going to continue to advocate and work in partnership with local officials and – and trusted voices to get the word out."[10] Then President-Elect Biden made nearly identical comments in response to a question about whether COVID-19 vaccines should be made mandatory, stating: "[n]o, I don't think it should be mandatory. I wouldn't demand it to be mandatory."[11]

56. But on September 9, 2021, everything changed. On that date, President Biden unveiled his "new plan to require more Americans to be vaccinated" by imposing "new vaccination requirements."[12] One such mandate would "require all employers with 100 or more employees, that together employ over 80 million workers, to ensure their workforces are fully vaccinated or show a negative test at least once a week."[13] Another would "require vaccinations" of "those who work in hospitals, home healthcare facilities, or other medical facilities—a total of 17 million healthcare workers."[14] Two others would "require all executive branch federal employees to be vaccinated – all" and "require federal contractors to do the same."[15] And the final one—relevant here—would "require all of nearly 300,000 educators in the federal paid program, Head Start program," to get vaccinated.[16] In total, President Biden's vaccine mandates affect over 80 million

[10] Jen Psaki, White House Press Briefing (July 23, 2021), https://www.whitehouse.gov/briefing-room/press-briefings/2021/07/23/press-briefing-by-press-secretary-jen-psaki-july-23-2021/.
[11] *Supra* n.5.
[12] *Supra* n.3.
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*; *see also* Covid-19 and the Head Start Community, https://eclkc.ohs.acf.hhs.gov/about-us/coronavirus/vaccination-head-start-staff (last visited Dec. 5, 2021).

Americans, a quarter of the total population of the United States, and one in three adult Americans.[17]

57. Like President Biden, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases under the Biden Administration, has also changed its position on vaccine mandates. Last year, he held an entirely different position than now: "You don't want to mandate and try and force anyone to take a vaccine. We've never done that." He continued, "[A vaccine mandate] would be unenforceable and inappropriate."[18] But now, Dr. Fauci supports "many, many more [vaccine] mandates."[19]

58. In line with this vaccine mandate flip flopping, on September 9, 2021, President Biden suddenly reversed course and announced that all Head Start employees had to be vaccinated against COVID-19.[20]

59. In relevant part, the announcement read, "To help ensure the safety of students, families, and their communities, the President's plan includes requirements that teachers and staff at Head Start and Early Head Start programs … get vaccinated. The Department of Health and Human Services (HHS) will initiate rulemaking to implement this policy for Head Start and Early Head Start programs, which provide comprehensive education and child development services to ensure that children are well prepared for kindergarten."[21]

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[17] *Id.*

[18] Joel Saget, *COVID-19 vaccine won't be mandatory in US, says Fauci*, Yahoo News, Aug. 19, 2020, https://www.yahoo.com/now/covid-19-vaccine-wont-mandatory-194038185.html.

[19] Carolyn Crist, *Fauci: 'Many, Many' More Vaccine Mandates Needed to End Pandemic*, WebMD News Brief, Sept. 13, 2021, https://www.webmd.com/vaccines/covid-19-vaccine/news/20210913/fauci-many-more-vaccine-mandates-needed-to-end-pandemic.

[20] https://www.acf.hhs.gov/ohs/news/biden-administration-requires-vaccination-head-start-staff (last visited Dec. 9, 2021).

[21] *Supra* n.6.

60. On November 30, 2021, HHS issued this challenged Interim Final Rule requiring that Head Start staff, contractors, and volunteers get vaccinated by January 31, 2022.

61. Although not announced ahead of time, the Interim Final Rule also immediately required universal masking of all individuals two years of age or older.[22]

62. The specific new rules are discussed in the Legal Background section of this Complaint.

B. The State of Texas's Response to the COVID-19 Pandemic

63. Since March 2020, Texas government officials have responded to the COVID-19 pandemic with a measured and deliberate approach specific to the needs of Texas and Texans. On March 19, 2020, Governor Abbott announced the first of many Executive Orders to control and combat the growing number of COVID-19 cases.[23] Texas has consistently sought to create a uniform response to the pandemic in accordance with the State's police power to protect public health and safety while also promoting and encouraging best practices to fight the spread of COVID-19.

64. As was reported nationwide throughout 2020, the number of COVID-19 cases grew, waned, and then grew again as summer approached, and Americans could no longer tolerate the restrictive measures many government officials had imposed. Throughout the entirety of the COVID-19 pandemic, Texas has exercised and sought to maintain its exclusive authority over the State's response to and recovery from the pandemic.[24]

65. In April 2021, Governor Abbott issued Executive Order GA-39, which in part ensured that individual medical autonomy was protected by providing that no governmental entity (including

[22] 86 Fed. Reg. at 68,101.
[23] The Governor's Executive Orders have the force and effect of State law and have been one of the State's primary tools in the fight against and recovery from COVID-19. *See, e.g.*, Tex. Gov't Code § 418.012.
[24] Tex. Gov't Code § 418.002(1), (3).

the LISD) could compel any individual to receive a COVID-19 vaccine administered under the emergency use authorization.[25] Recognizing that federal government overreach was impending and that the right to choose whether to take the vaccine could be stripped from all Texans, Governor Abbott issued GA-40 on October 11, 2021. GA-40 further protected personal liberty and autonomy and made it illegal for *any* entity in Texas (including the LISD) to compel receipt of a COVID-19 vaccine by any individual, including an employee or a consumer, who objected to such vaccination "for any reason of personal conscience, based on a religious belief, or for medical reasons, including prior recovery from COVID-19."[26]

66. Governor Abbott and the State of Texas have made it clear to Texans: the decision whether to receive a vaccine should be free from governmental control. In response, millions of Texans have enthusiastically adopted best practices for public health and safety, including widespread uptake of the COVID-19 vaccine. So far in Texas, over 66% of the total Texan population eligible for vaccines are fully vaccinated.[27] Despite Texas's diversity and largely rural character, Texas ranks above many states in vaccination rates—all without any government vaccine mandate.[28]

67. Nonetheless, according to the Interim Final Rule,

> State and local laws that forbid employers in the State or locality from imposing vaccine requirements on employees directly conflict with this exercise of our statutory authority to protect the health and safety of Head Start participants and

[25] GA-39 is publicly available at https://gov.texas.gov/uploads/files/press/EO-GA-39_prohibiting_vaccine_mandates_and_vaccine_passports_IMAGE_08-25-2021.pdf (last visited Dec. 8, 2021).
[26] GA-40 is publicly available at https://gov.texas.gov/uploads/files/press/EO-GA-40_prohibiting_vaccine_mandates_legislative_action_IMAGE_10-11-2021.pdf (last visited Dec. 8, 2021).
[27] Texas Coronavirus Vaccination Progress, https://usafacts.org/visualizations/covid-vaccine-tracker-states/state/texas (last visited Dec. 8, 2021).
[28] *See, e.g.*, CDC COVID Data Tracker, https://covid.cdc.gov/covid-data-tracker/#county-view (last visited Dec. 8, 2021).

> their families and ensure the continuation of services by requiring vaccinations for staff, certain contractors, and volunteers and universal masking. As is relevant here, this [Interim Final Rule] preempts the applicability of any State or local law providing for exemptions to the extent such law provides broader grounds for exemptions than provided for by Federal law and are inconsistent with this [Interim Final Rule]. In these cases, consistent with the Supremacy Clause of the Constitution, the agency intends that this rule preempts State and local laws to the extent the State and local laws conflict with this rule.

86 Fed. Reg. at 68,063.

C. LISD's Response to the COVID-19 pandemic

68. LISD safely welcomed students back into its buildings for the 2020-2021 school year. In line with Governor Abbott's Executive Order and TEA Public Health Guidance, LISD implemented a mask mandate for all staff and for students in 4th grade and above. While younger students had the option to wear masks, LISD did not require them for multiple reasons.[29]

69. First and foremost, masks inhibit a young child's ability to effectively learn language and social skills. Secondly, the management of enforcing a mask mandate with young children is challenging in that young children are more apt to drop them, play with them, sneeze and cough in them. Lastly, the science we read indicated that younger children were at far less risk of contracting COVID-19 or getting extremely sick with COVID-19. Overall, LISD believed that the negative effects of wearing masks in Pre K through 3rd grades were far greater than what protection they provided. While LISD's mask mandate remained in effect for the entirety of the school year, at no time did LISD require students below the 4th grade to wear masks.[30]

70. As LISD prepared for the 2021-2022 school year, LISD determined that its stance would be that masks are welcome, and vaccinations are encouraged. The word "welcome" with regard

[29] *See* Declaration of LISD Superintendent Dr. Kathy Rollo, Exhibit 3, ¶ 4.
[30] *Id.*

to masks was strategically selected because LISD wanted staff, students, and families to make the decision that best met their needs.[31]

71. LISD has encouraged vaccinations since they were first made available. LISD has achieved a high rate of staff vaccination without a mandate. In an anonymous survey conducted in August before school started, 84% of LISD's staff reported having received at least one vaccine dose.[32]

VI. ARGUMENT

A. Plaintiffs are harmed by the Interim Final Rule.

72. The Vaccine Mandate and the Mask Mandate directly injure Texas and the LISD.

73. Defendants are attempting to use the Head Start program as a lever to force Americans who happen to work, contract, or volunteer at a Head Start program to receive unwanted medical treatment, and to compel Americans to force their children to wear masks while attending Head Start, in violation of foundational principles of American law.

74. Texas and LISD citizens participate in the Head Start program as parents, faculty, staff, contractors, and volunteers, and, most importantly, as students enrolled in the program.[33] Programs operated by state and local governments are required to impose the Head Start Vaccine Mandate on their employees to comply with the Interim Final Rule's burdensome requirements.

75. Head Start Programs at Texas schools have district employees who monitor compliance with Head Start program requirements. The Vaccine Mandate seeks to commandeer those employees to become enforcers of Defendants' unlawful attempt to federalize state and local

[31] *Id.* at ¶ 5.
[32] *Id.* at ¶ 6.
[33] *See* Declaration of Vice Chancellor and General Counsel of Texas Tech University System, Eric Bentley, attached as Exhibit 4.

vaccine policies and override Texas's police power on matters of health and safety while simultaneously overriding the District's policies by executive fiat.

76. By requiring Head Start programs and Texas public schools to enforce the Vaccine Mandate, both LISD and the State of Texas will face increased implementation and enforcement costs.

77. Further, by requiring Head Start programs and Texas public schools to enforce the Vaccine Mandate, that mandate directly infringes Texas's sovereign and quasi-sovereign authority.

78. Texas is injured because the Head Start Vaccine Mandate purports to preempt its state and local laws on matters of vaccines and the rights of its citizens. This violates Texas's "sovereign interest in the power to create and enforce a legal code." *Texas v. United States*, 809 F.3d 134, 153 (5th Cir. 2015) (quotation omitted). It also violates Texas's sovereign right to exercise its police power on matters such as compulsory vaccination.

79. The Governor of Texas has issued an executive order prohibiting mandatory vaccination requirements by entities in Texas. Texas EO GA-40 (Oct. 11, 2021). However, the Vaccine Mandate purports to "preempt[] the applicability of any State or local law providing for exemptions to the extent such law provides broader grounds for exemptions than provided for by Federal law and are inconsistent with the Interim Final Rule. In these cases, purportedly under the Supremacy Clause of the Constitution, the agency intends that this rule preempts State and local laws to the extent the State and local laws conflict with this rule." 86 Fed. Reg. at 68,063.

80. Texas will suffer other pocketbook injuries. The Vaccine Mandate requires Head Start programs and participating Texas public schools to maintain documentation of their staff's

vaccination status, supply masks, and cover the costs of weekly COVID-19 testing. 86 Fed. Reg. at 68,601.

81. Texas has a quasi-sovereign and *parens patriae* interest in protecting the rights of its citizens and vindicating them in court. Texas thus may sue to challenge unlawful actions that "affect the [States'] public at large." *In re Debs*, 158 U.S. 561, 584 (1895).

82. A natural and predictable consequence of the Vaccine Mandate is that numerous Head Start faculty, staff, contractors, and volunteers may be fired, retire, or quit. Texas Head Start programs and state schools face the Catch-22 of program closures due to staffing shortages or closure due to the loss of Head Start funding. The effect on smaller communities in Texas would be devastating. A recent survey found that 86% of child care centers are facing staffing shortages.[34] According to the Bureau of Labor Statistics, 166,900 fewer people worked in child care in December 2020 than in December 2019, when the industry employed about 1,040,400 people.[35] In addition, a recent survey determined that four in five child care centers in the U.S. are understaffed.[36]

83. In addition to staffing shortages generally, a reduction of staff may result in program closures. There have already been examples of this in the U.S.[37]

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[34] State Survey Data: Child Care at a Time of Progress and Peril, Sept. 2021, https://www.naeyc.org/sites/default/files/wysiwyg/user-74/statedata_july2021_gf_092321.pdf.

[35] Child Care Industry Increasingly Fragile as Programs Face Staffing Challenges, Foundations for Families, Dec. 7, 2021, https://foundationsforfamilies.com/child-care-industry-increasingly-fragile-as-programs-face-staffing-challenges/.

[36] SURVEY: Four in five childcare centers in the U.S. are understaffed, NAEYC, July 27, 2021, https://www.naeyc.org/about-us/news/press-releases/survey-childcare-centers-understaffed.

[37] *See, e.g.*, Stephanie Ebbert, *Child-care providers are facing a staffing crisis, forcing some to close with little notice to parents*, Boston Globe, Aug. 17, 2021,

84. Defendants acknowledge the harm that will result from this: "[P]rogram closures [] create instability and stress for children and families. They disrupt children's opportunities for learning, socialization, nutrition, and continuity and routine." 86 Fed. Reg. at 68,057. The program closures also harm the low-income communities Head Start programs are intended to serve. Defendants also acknowledge this harm: "Balancing working from home and supporting children was the number one challenge for parents" during the pandemic. *Id.* "This challenge was especially acute for families with multiple children in different grade levels or with one child under the age of four years." *Id.* Defendants describe many more harms that it contends result from program closures in the Interim Final Rule, such as children missing out on nutritious meals. *Id.*

85. In addition to the already-existing staffing shortage, the Vaccine Mandate now threatens to cause further hardship to the Head Start Programs, particularly in rural communities. Mandating that state-run programs terminate staff who refuse vaccination will lead to a reduction in healthcare services. [38] If these programs lose even a few staff, services will be halted, and low-income families will have to attempt to find another form of child care. Low-income communities simply do not have enough affordable child care programs to replace those that are currently open.

86. Texas is injured because the Vaccine Mandate discriminates between citizens of Texas who are vaccinated and those who are not by denying the latter employment opportunities available to the former. Texas has a quasi-sovereign and *parens patriae* interests in protecting their citizens from

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https://www.bostonglobe.com/2021/08/17/metro/child-care-providers-are-facing-staffing-crisis-forcing-some-close-with-little-notice-parents/.

[38] *See, e.g.*, Chad Frey, *Vaccine mandate affecting Newton Head Start staff*, the Kansas, Nov. 9, 2021, https://www.thekansan.com/story/news/2021/11/09/head-start-staff-can-pursue-religious-ada-based-exemptions-mandate/6345213001/ ("Sara Livesay, principal at Cooper, said the [head start] program could not continue if the district fired staff that have voiced protests to vaccinations. More than half of the licensed teaching staff has told her they will not get vaccinated.").

discriminatory policies. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico, ex rel., Barez*, 458 U.S. 592, 609 (1982) ("This Court has had too much experience with the political, social, and moral damage of discrimination not to recognize that a State has a substantial interest in assuring its residents that it will act to protect them from these evils.").

87. There is also the real concern of harm to the development to children participating in the Texas-based Head Start programs, including emotional, social, speech, and other areas of development.[39]

88. In addition, the rule identifies 38% of children as dual language learners, with a language other than English spoken in the home (sometimes in addition to English). 86 Fed. Reg. at 68,057. There is a risk of harming bilingual students, who make up a significant portion of students in Head Start programs as being able to see mouth movements is critical to language development.[40]

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[39] Gori, M., Schiatti, L., & Amadeo, M. B., *Masking Emotions: Face Masks Impair How We Read Emotions*, Frontiers in Psychology, May 25, 2021, https://doi.org/10.3389/fpsyg.2021.669432 (findings that may potentially affect the development of social and emotion reasoning, and young children's future social abilities should be monitored to assess the true impact of the use of masks); Green, J., et. al., *The implications of face masks for babies and families during the COVID-19 pandemic: A discussion paper*, Journal of Neonatal Nursing, Feb. 2021, https://doi.org/10.1016/j.jnn.2020.10.005 ("The difficulty in determining what facial expression a person is exhibiting behind a mask may present challenges for infants and young children as they depend on their parents' facial expressions, coupled with tone and/or voice to regulate their reactions toward others. Health professionals should understand the potential effects of prolonged mask wearing to minimise any potential long-term impact on neonatal development and optimise babies, infants, children and their parents."); Lewkowicz, D. J., & Hansen-Tift, A. M., *Infants deploy selective attention to the mouth of a talking face when learning speech*, Proceedings of the National Academy of Sciences of the United States of America, Jan. 2012, https://doi.org/10.1073/pnas.1114783109; *see also* Declaration of Lubbock ISD Superintendent Dr. Kathy Rollo, Exhibit 3, ¶¶ 7,9.

[40] Weikum, W. M., et al., *Visual language discrimination in infancy*, Science, May 25, 2007, https://doi.org/10.1126/science.1137686; Pons, F., Bosch, L., & Lewkowicz, D. J., *Bilingualism modulates infants' selective attention to the mouth of a talking face*, Psychological science, Apr. 2015,

89. Declaratory relief announcing that the Head Start Vaccine Mandate is unlawful, an injunction enjoining its enforcement, and an order setting aside the Head Start Vaccine Mandate will remedy these harms to Texas's interests.

B. The Interim Final Rule lacks statutory authority.

90. The Interim Final Rule was issued by the Office of Head Start, the Administration for Children and Families, and HHS. 86 Fed. Reg. at 68,052. The Office of Head Start is within the Office of Early Child Development, which is in the Administration for Children and Families, which is in HHS. Those entities are federal agencies, or parts of federal agencies, subject to the requirements of the Administrative Procedure Act.

91. Under the APA, courts must "hold unlawful and set aside agency action" that is "not in accordance with law" or "in excess of statutory . . . authority[] or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A), (C).

i. Congress did not authorize Defendants to mandate vaccinations or masks.

92. An agency may implement a rule only when Congress authorizes it to do so. "[A]n agency literally has no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986). Agency actions that do not fall within the scope of a statutory delegation of authority are *ultra vires* and must be invalidated.

93. Defendants cite 42 U.S.C. § 9836a(a)(1)(C), (D), and (E) as its authority for issuing the vaccine and mask mandate. 86 Fed. Reg. at 68,053. Those subsections provide: "The Secretary

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https://doi.org/10.1177/0956797614568320; Joan Birulé, et. al., *Inside bilingualism: Language background modulates selective attention to a talker's mouth*, Developmental Science, Sept. 25, 2018, https://doi.org/10.1111/desc.12755.; *see also* Declaration of Lubbock ISD Superintendent Dr. Kathy Rollo, Exhibit 3 at ¶¶ 7,9.

shall modify, as necessary, *program performance standards* by regulation applicable to Head Start agencies and programs under this subchapter, including (C) administrative and financial management standards; (D) standards relating to the condition and location of facilities (including indoor air quality assessment standards, where appropriate) … [and] (E) such other standards as the Secretary finds to be appropriate [emphasis added]."

94. Section 9836a authorizes the Secretary to regulate "program performance standards," it does not authorize defendants to mandate an invasive, permanent medical treatment for or mask mandates for Head Start program children, staff, contractors, and volunteers. Notably, it does not mention vaccinations or masking requirements at all.

ii. Defendants do not have limitless authority to regulate health and safety within Head Start programs.

95. The Interim Final Rule's "purpose . . . is to protect the health and safety of Head Start staff, children, and families and to mitigate the spread of [COVID-19] in Head Start programs." 86 Fed. Reg. at 68,053. Defendants assert that they have authority to mandate COVID-19 vaccination of staff, contractors, and volunteers because of the purported "statutory authority to protect the health and safety of Head Start participants and their families and ensure the continuation of services." 86 Fed. Reg. at 68,063.

96. Defendants' assertion that their authority to set appropriate health and safety standards for the conditions Head Start facilities grants them unfettered authority to generally regulate the "health and safety" of staff, contractors, volunteers, and students is unfounded. 86 Fed. Reg. at 68,054.

97. "The Secretary's administrative authority is undoubtedly broad. But it is not boundless." *Merck & Co. v. United States Dep't of Health & Hum. Servs.*, 962 F.3d 531, 537–38 (D.C. Cir. 2020) (citations omitted) (discussing authority of CMS, a division of HHS).

98. Defendants' assertion of authority to issue a vaccine mandate under vague statutory language generally referencing health and safety creates a "serious danger," if allowed to stand, that Defendants will "choose to broadly exert power in a variety of contexts." *Cf. Am. Health Care Ass'n v. Burwell*, 217 F. Supp. 3d 921, 934–35 (N.D. Miss. 2016) (discussing an assertion of authority by CMS).

99. Permitting Defendants to exercise such boundless authority would render the separation-of-powers principles set forth in the United States Constitution meaningless.

100. Just this year, the Supreme Court rejected the assertion by a federal agency of such broad authority based on vague statutory language. The authority granted an agency by statute is not based on vague language in isolation but is informed by the context in which that language appears. *See Alabama Ass'n of Realtors v. Dep't of Health and Hum. Servs.*, 141 S. Ct. 2485, 2488 (2021) ("The Government contends that the first sentence of § 361(a) gives the CDC broad authority to take whatever measures it deems necessary to control the spread of COVID–19, including issuing the moratorium. But the second sentence informs the grant of authority by illustrating the kinds of measures that could be necessary: inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of contaminated animals and articles. These measures directly relate to preventing the interstate spread of disease by identifying, isolating, and destroying the disease itself. . . . Reading both sentences together, rather than the first in isolation, it is a stretch to maintain that § 361(a) gives the CDC the authority to impose this eviction moratorium.").

101. Section 9836a authorizes Defendants to implement performance standards, but that authority is circumscribed by the statute's context.

102. "Performance standards" is not defined in § 9836a. But "performance standards" is a plain and unambiguous term so the ordinary definition applies. *Carcieri v. Salazar*, 555 U.S. 379, 387 (2009) ("This case requires us to apply settled principles of statutory construction under which we must first determine whether the statutory text is plain and unambiguous. If it is, we must apply the according to its terms.") (cleaned up).

103. Ordinarily, a "performance standard" is a threshold criterion to measure quality or acceptability of a required or contractual action.[41]

104. Here, the program performance standards are standards to measure a program's quality and conditions in terms of administration, facilities, and education of the Head Start programs. *See* 42 U.S.C. § 9836a (discussing performance standards concerning "service provided," "education performance standards," "administrative and financial management standards," and "standards relating to the condition and location of facilities").

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[41] *See* STANDARD, Black's Law Dictionary (11th ed. 2019) ("2. A criterion for measuring acceptability, quality, or accuracy <the attorney was making a nice living — even by New York standards>. — standard, *adj.*"); PERFORMANCE, Black's Law Dictionary (11th ed. 2019) ("performance *n.* (16c) 1. The successful completion of a contractual duty"); *see also* Developing Performance Standards (opm.gov) https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/planning/developing-performance-standards/ ("A performance standard is a management-approved expression of the performance threshold(s), requirement(s), or expectation(s) that must be met to be appraised at a particular level of performance."); *see*, *e.g.*, *Salmon v. Soc. Sec. Admin.*, 663 F.3d 1378, 1383 (Fed. Cir. 2011) ("Performance standard means the management-approved expression of the performance threshold(s), requirement(s), or expectation(s) that must be met to be appraised at a particular level of performance[.]"); *Wilson v. Dep't of Health & Hum. Servs.*, 770 F.2d 1048, 1053 (Fed. Cir. 1985) ("A performance standard for this critical element defines minimally acceptable performance for this activity[.]").

105. Further, this understanding of the term "performance standards" is supported by the purpose of the Improving Head Start for School Readiness Act of 2007 (Pub. L. 110–134). The Act is intended to improve the current Head Start Program by: (1) increasing competition among Head Start providers; (2) improving the coordination of early childhood delivery systems; (3) requiring stronger educational and performance standards for Head Start teachers and staff; and (4) requiring financial accountability to ensure that all funds are being used properly to serve the educational needs of the children. 2007 U.S.C.C.A.N. S17, 2007 WL 4984163 (Leg. Hist.).

106. Defendants' authority is circumscribed by the context of the statute. "Performance standards" is not a term that authorizes unlimited wishes of Defendants. "Congress . . . does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). These subsections relate to "program performance standards." Although Defendants attempt to cram an elephant in a mousehole with this rule, authority to implement program performance standards does not extend to mandating an invasive medical procedure or mask mandates.

107. Compare if the CDC—which (unlike Defendants) has authority to "make and enforce such regulations … necessary to prevent the introduction, transmission, or spread of communicable diseases," *Alabama Ass'n of Realtors*, 141 S. Ct. at 2487 (quoting 42 U.S.C. § 264(a))—cannot issue an eviction moratorium to control the spread of communicable diseases, *id.* at 2489, then Defendants, lacking similar authority, cannot regulate the medical treatment of staff or other individuals by mandating vaccinations.

108. Defendants' read of 42 U.S.C. § 9836a and vague reference in the Interim Final Rule to health and safety, "would give [Defendants] a breathtaking amount of authority." *Id.* at 2489. "It is hard to see what measures this interpretation would place outside [Defendants'] reach, and the Government has identified no limit in [this authority] beyond the requirement that [Defendants'] deem a measure 'necessary.'" *Id.* at 2489.

109. Defendants' assertion of such expansive authority under 42 U.S.C. § 9836a and vague reference in the Interim Final Rule to "health and safety," is unprecedented, "not in accordance with the law," "in excess of [its] statutory . . . authority," "in excess of statutory . . . limitations," and "short of [its] statutory right." 5 U.S.C. § 706(2)(A), (C).

iii. Defendants do not explain how the Vaccine Mandate and the Mask Mandate are authorized by section 9836a.

110. The 49-page Interim Final Rule does not explain or even mention how the amendments to 45 C.F.R. §§ 1302.047 (Mask Mandate), .093 (Vaccine Mandate for staff), or .094 (Vaccine Mandate for volunteers) might be justified as a program performance standard of any kind, let alone a program performance standard that is also an administrative standard, a financial management standard, or a standard relating to the location of facilities. And the amendments are not in fact any of those types of standards.

111. The Interim Final Rule contains one sentence which is seemingly intended to explain how the amendments to 45 C.F.R. §§ 1302.047, .093, and .094 announced in the Interim Final Rule are a "standard relating to the condition … of facilities": "The Secretary finds it necessary and appropriate to set health and safety standards for the condition of Head Start facilities that ensure the reduction in transmission of the SARS-CoV-2 and to avoid severe illness, hospitalization, and death among program participants." 86 Fed. Reg. at 68,054. But by its terms, this sentence refers

to "health and safety standards," not to a "standard relating to the condition … of facilities." Moreover, health and safety requirements for employees, volunteers, and children simply are not standards about the condition of facilities. They are standards about the condition of people.

112. Thus, the amendments to 45 C.F.R. §§ 1302.047, .093, and .094 announced in the Interim Final Rule are not administrative standards, financial management standards, or standards relating to the condition or location of facilities—and Defendants do not even claim that they are. Thus, they are not in fact justified under 42 U.S.C. § 9836a(a)(1)(C) or (D).

113. The Interim Final Rule also does not explain or even mention how the amendments to 45 C.F.R. §§ 1302.047, .093, or .094 might be justified as an "other standard[] as the Secretary finds to be appropriate" under subsection (a)(1)(E). Subsection (a)(1)(E) cannot justify the Interim Final Rule—or anything else—because it violates the non-delegation doctrine. "The nondelegation doctrine bars Congress from transferring its legislative power to another branch of Government." *Gundy v. United States*, 139 S. Ct. 2116, 2121 (2019). "[A] nondelegation inquiry always begins (and often almost ends) with statutory interpretation. The constitutional question is whether Congress has supplied an intelligible principle to guide the delegee's use of discretion." *Id.* at 2123. Subsection (a)(1)(E) does not contain such an intelligible principle. "Appropriate" is not an intelligible principle. Therefore, subsection (a)(1)(E) is unconstitutional and cannot justify the Interim Final Rule.

114. If Defendants' logic is that the Vaccine Mandate and the Mask Mandate can be implemented because the Secretary can implement "other standards as the Secretary finds to be appropriate" under subsection (a)(1)(E), then the same logic would support the implementation of any "performance standard" Defendants might wish to impose on Head Start staff and children,

such as mandating flu vaccines or weekly RSV testing. This would be limitless, unguided authority in violation of the non-delegation doctrine.

115. In addition to specifically citing 42 U.S.C. § 9836a(a)(1)(C), (D), and (E), Defendants also claim, "There are two primary reasons that [the Administration for Children and Families] decided to mandate vaccination and mask use." 86 Fed. Reg. at 68,066. The first asserted "primary reason" will be discussed in the next section. The second asserted "primary reason" for the vaccine and mask mandate is:

> Second, as discussed in this [Interim Final Rule], being fully vaccinated for COVID-19 and using a mask are two of the most effective mitigation strategies available to reduce transmission of COVID-19 [citing Centers for Disease Control and Prevention, "Science Brief: COVID-19 Vaccines and Vaccination," September 15, 2021]. With this in mind, [the Administration for Children and Families] determined a federal requirement is necessary. While some agencies and localities have implemented vaccine and masking requirements, many have not. Additionally, vaccine uptake among Head Start staff has not been as robust as hoped for and has been insufficient to protect the health and safety of children and families receiving Head Start services. Combined, these factors leave certain children and families with fewer mitigation strategies in place to protect them than others. It is ACF's responsibility to make sure the environment is as safe as possible for Head Start programs uniformly across all 1,600 grant recipients.

86 Fed. Reg. at 68,066.

116. This second "primary reason" is nothing but a naked assertion that something needs to be done, without any effort to justify the mandate with any statutory authority.

117. Although it does not say so, perhaps this second "primary reason" is supposed to be justified by subsection (a)(1)(E) ("such other standards as the Secretary finds to be appropriate"). If so, then it cannot stand because subsection (a)(1)(E) violates the non-delegation doctrine.

iv. Congress did not authorize the scope of authority claimed by Defendants.

118. A vaccine mandate is distinct from requiring performance standards. It is a mandate that staff, volunteers, and contractors submit to a specific medical treatment. Likewise, weekly COVID-19 testing and mask mandates are distinct from performance standards. These requirements are not a measure of educational quality, or even of the quality of facilities from a health and safety standpoint. Further, although Defendants can implement performance standards concerning the condition of Head Start facilities, conditions of *facilities* are separate and distinct from conditions of *individuals*. Likewise, it boggles the mind to comprehend how a performance standard for an individual—a measure of meeting minimum thresholds of a required action, such as an employee duty in an employment contract—can stretch to include minimum medical treatment requirements.

119. As stated above, the purpose of the Improving Head Start for School Readiness Act is to (1) increase competition among Head Start providers; (2) improve the coordination of early childhood delivery systems; (3) require stronger educational and performance standards for Head Start teachers and staff; and (4) require financial accountability to ensure that all funds are being used properly to serve the educational needs of the children.[42]

120. This is reiterated in the purpose statement of the Act:

> It is the purpose of this subchapter to promote the school readiness of low-income children by enhancing their cognitive, social, and emotional development--
>
> (1) in a learning environment that supports children's growth in language, literacy, mathematics, science, social and emotional functioning, creative arts, physical skills, and approaches to learning; and

[42] 2007 U.S.C.C.A.N. S17, 2007 WL 4984163 (Leg. Hist.).

> (2) through the provision to low-income children and their families of health, educational, nutritional, social, and other services that are determined, based on family needs assessments, to be necessary.

42 U.S.C. § 9831.

121. Nowhere in the Act are Defendants authorized to mandate an invasive, permanent medical treatment for staff or any individuals or mandate mask-wearing and weekly COVID-19 testing. These are all medical mandates, not performance standards.

122. The authority Defendants rely on to implement the Interim Final Rule does not grant Defendants the authority sought to exercise via the Vaccine Mandate and the Mask Mandate.

123. "[T]he sheer scope of [Defendants] claimed authority … would counsel against" Defendants' broad view of their own authority. *Ala. Ass'n of Realtors*, 141 S. Ct. at 2489. The Supreme Court "expect[s] Congress to speak clearly when authorizing an agency to exercise powers of vast economic and political significance." *Id.* (quotation marks omitted) (quoting *Utility Air Regulatory Grp. v. EPA*, 573 U.S. 302, 324 (2014)). "That is exactly the kind of power that [Defendants] claim[] here." *Id.*

124. Defendants assert that under the Head Start Vaccine Mandate, they "anticipate that the requirement that all Head Start staff get fully vaccinated for COVID–19 will induce a substantial portion of unvaccinated staff to get fully vaccinated." 86 Fed. Reg. at 68,064. Defendants also "estimate that the regulation will induce a similar number, but smaller share, of unvaccinated Head Start volunteers to get fully vaccinated. *Id.*

125. Defendants estimate that over 820,000 staff, over 637,000 volunteers, and almost 2.6 million children will fall under the mandate. 86 Fed. Reg. at 68,077, 68,094.

126. Defendants estimate that the costs associated with the Head Start Vaccine Mandates will be up to $71.42 million in turnover costs alone. *Id.* at 68,092. This does not include any costs training new volunteers, finding new contractors, or opening a new program because another shut down due to the mandate.

127. If Defendants can mandate medical treatment for 1.45 million individuals, 86 Fed. Reg. at 68,094, not including contractors, it "would give [Defendants] a breathtaking amount of authority," and "[i]t is hard to see what measures this interpretation would place outside [Defendants'] reach." *Ala. Ass'n of Realtors*, 141 S. Ct. at 2489.

128. Defendants' authority does not extend to exercising powers of vast economic and political significance without limit as it attempts with the Head Start Vaccine Mandate.

129. "Congress . . . does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." *Whitman*, 531 U.S. at 468.

* * *

130. There is no valid statutory authority for the Interim Final Rule. Defendants are not authorized to mandate vaccinations for its staff and volunteers or the wearing of masks for its staff and volunteers or the children and family members while they are at Head Start facilities.

131. The Court should set aside the Interim Final Rule. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be … not in accordance with law [or] in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A), (C).

C. The Interim Final Rule is not simply an extension of preexisting regulations.

132. The first asserted "primary reason" for the Interim Final Rule is:

> First, Head Start programs have a broad set of program performance standards that already include requirements for infection control, exclusion policies, cleaning, sanitizing and disinfecting. The requirement for staying home when sick is part of § 1302.47(b)(4)(i)(A); hand hygiene (handwashing) is included at § 1302.47(b)(6)(i); cleaning, sanitizing, and disinfecting is at § 1302.47(b)(2)(i); and physical distancing is part of § 1302.47(b)(4)(i)(A), which [the Office of Head Start] sees as a strategy for a program's infection control practices) [sic]. In addition, § 1302.47(b)(1)(iii) states that facilities need to be 'free from pollutants, hazards and toxins that are accessible to children and could endanger children's safety,' though it is difficult be overly prescriptive about ventilation given the range of facilities and spaces used by center-based and family child care programs.

86 Fed. Reg. at 68,066 (unmatched right parenthesis in original).

133. In other words, Defendants are asserting that rules in place before the Interim Final Rule "already include" various requirements, and those various requirements themselves justify the Vaccine Mandate and the Mask Mandate. This assertion would be more appropriate for an interpretive rule, or an informal interpretation of Defendants' own regulations, neither of which must be formally promulgated. But the Interim Final Rule is neither, so this assertion is pointless.

134. Moreover, Defendants' characterizations of the rules relied upon in the first "primary reason" do not match the text of those rules.

135. 45 C.F.R. § 1302.47(b)(4)(i)(A) states: "All staff with regular child contact have initial orientation training within three months of hire and ongoing training in all state, local, tribal, federal and program-developed health, safety and child care requirements to ensure the safety of children in their care; including, at a minimum, and as appropriate based on staff roles and ages of children they work with, training in [t]he prevention and control of infectious diseases." Contrary

to Defendants' assertion, this provision does not include "[t]he requirement for staying home when sick" or "physical distancing." This is a staff training regulation.

136. 45 C.F.R. § 1302.47(b)(6)(i) specifies: "All staff systematically and routinely implement hygiene practices that at a minimum ensure [a]ppropriate toileting, hand washing, and diapering procedures are followed." Contrary to Defendants' assertion, this is not a general "hand hygiene (handwashing)" requirement, but instead refers to cleaning up after urination and defecation.

137. 45 C.F.R. § 1302.47(b)(2)(i) reads: "Indoor and outdoor play equipment, cribs, cots, feeding chairs, strollers, and other equipment used in the care of enrolled children, and as applicable, other equipment and materials meet standards set by the Consumer Product Safety Commission (CPSC) or the American Society for Testing and Materials, International (ASTM). All equipment and materials must at a minimum [b]e clean and safe for children's use and are appropriately disinfected." Contrary to Defendants' assertion, this provision is not a general "cleaning, sanitizing, and disinfecting" requirement, but only requires that equipment be kept clean.

138. 45 C.F.R. § 1302.47(b)(1)(iii) reads: "All facilities where children are served, including areas for learning, playing, sleeping, toileting, and eating are, at a minimum [f]ree from pollutants, hazards and toxins that are accessible to children and could endanger children's safety." Defendants comment, "it is difficult be overly prescriptive about ventilation given the range of facilities and spaces used by center-based and family child care programs." This comment shows that Defendants understand this requirement to concern "ventilation." If Defendants are trying to justify the vaccine and mask mandate on a theory that ventilation at Head Start facilities is somehow inadequate, that will not work. This rule requires that ventilation be adequate. It does

not allow Head Start facilities to replace inadequate ventilation with vaccine and mask requirements. Thus, contrary to Defendants' assertion, this rule cannot support the vaccine and mask mandate.

139. In sum, Defendants' assertion that "Head Start programs [already] have a broad set of program performance standards that already include requirements for infection control, exclusion policies, cleaning, sanitizing and disinfecting" is such an exaggeration of its legal authority that it is simply false.

140. Similarly, Defendants also claim, "The Head Start Program Performance Standards require children to be up to date on immunizations and their state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule (45 CFR 1302.42(b)(1)(i)). When children are behind on immunizations or other care, Head Start programs are required to ensure they get on a schedule to catch up." 86 Fed. Reg. at 68,059. This is false. 45 C.F.R. § 1302.42(b)(1)(i) actually states:

> **(1)** Within 90 calendar days after the child first attends the program or, for the home-based program option, receives a home visit, with the exceptions noted in paragraph (b)(3) of this section, a program must:
>
> **(i)** Obtain determinations from health care and oral health care professionals as to whether or not the child is up-to-date on a schedule of age appropriate preventive and primary medical and oral health care, based on: The well-child visits and dental periodicity schedules as prescribed by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the state in which they operate, immunization recommendations issued by the Centers for Disease Control and Prevention, and any additional recommendations from the local Health Services Advisory Committee that are based on prevalent community health problems;
>
> **(ii)** 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 with parent consent as described in § 1302.41(b)(1).

141. Thus, Head Start programs are required to find out if children are up to date on "immunization recommendations issued by the Centers for Disease Control" and must "assist parents with making arrangements to bring the child up-to-date as quickly as possible," ***but only with parental consent***. This rule does not justify requiring children to wear masks without parental consent.

142. Moreover, even if existing regulations really did already require that children be up to date on vaccinations, that would neither justify the Vaccine Mandate for staff, and nor would it justify the Mask Mandate for children, especially for children under five who are too young to be vaccinated.

143. Defendants build on this false claim by further claiming, "It is equally important [as the false requirement that children to be up to date on immunizations] that the Head Start program itself is safe for all children, families, and staff. For this reason, the Head Start Program Performance Standards specify that the program must ensure staff do not pose a significant risk of communicable disease (45 CFR 1302.93(a))." In fact, that rule reads,

> A program must ensure each staff member has an initial health examination and a periodic re-examination as recommended by their health care provider in accordance with state, tribal, or local requirements, that include screeners or tests for communicable diseases, as appropriate. The program must ensure staff do not, because of communicable diseases, pose a significant risk to the health or safety of others in the program that cannot be eliminated or reduced by reasonable accommodation, in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

The rule thus refers to staff that already have a communicable disease that constitutes a disability, not to staff that might temporarily be infected by an airborne virus at some unspecified time in the

future. This rule does not allow Head Start to require that its employees get vaccinated. It does not justify the Vaccine Mandate.

144. 42 U.S.C. § 9842(a)–(b) reads:

> Each recipient of financial assistance under this subchapter shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such financial assistance, the total cost of the project or undertaking in connection with which such financial assistance is given or used, the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit. The Secretary . . . shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the financial assistance received under this subchapter.

Defendants cites to this as a basis for requiring that head start recipients collect and store records relating to the vaccination status of staff and volunteers. However, as seen by the statute's context, these provisions only authorize Defendants to collect information pertinent to auditing the amount and disposition of the financial assistance received by a recipient. This does not authorize the collection of medical records and documentation relating to the vaccination status of staff and volunteers. Whether staff are vaccinated or not is irrelevant to the amount and disposition of financial assistance proceeds received by a recipient.

145. In short, the Interim Final Rule cannot be justified as merely an extension of already existing regulations. And extending already existing regulations is not authority for a new regulation.

D. The Interim Final Rule is arbitrary and capricious.

146. "Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the

product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

147. Defendants did not engage in reasoned decision-making, but instead acted arbitrarily and capriciously, in issuing the Interim Final Rule.

148. Defendants acted arbitrarily and capriciously by enforcing a vaccine mandate against Head Start staff, while there is no such mandate for staff in K through 12 schools. That decision makes no sense.

149. Defendants acted arbitrarily and capriciously by enforcing a vaccine mandate against Head Start staff, while the federal government does not enforce the vaccine mandate against federal employees.

150. Defendants acted arbitrarily and capriciously by ignoring or arbitrarily rejecting the adverse effects resulting from resignations of unvaccinated Head Start workers who do not want to be vaccinated, and the withdrawal of children from families who do not want to wear masks.

151. Defendants acted arbitrarily and capriciously by ignoring or arbitrarily rejecting the interests of Head Start workers who—for any number of varying personal reasons—do not want to take one of the currently authorized COVID-19 vaccines.

152. Defendants acted arbitrarily and capriciously by refusing to provide a testing option for Head Start employees who decline to take one of the available COVID-19 vaccines. Defendants know that OSHA provided this option in its recently struck down vaccine mandate for employers, but nonsensically assert:

> Whereas OSHA allows employers to offer an option for testing and face coverings, this [Interim Final Rule] does not permit a testing and face coverings option for individuals without an approved vaccine exemption. The rationale for the difference is that [the Administration for Children and Families] is acting under

> statutory and regulatory standards that are different from OSHA's. In general, the Head Start Act requires standards for a safe environment for staff, children, and other participants.

86 Fed. Reg. at 68,061. The second sentence proves too much. Of course, they are different. But Defendants do not explain why the differences justify differing rules. The third sentence falsely suggests that Defendants have the general power to do anything they want in the name of "safe environments," while simultaneously falsely suggesting that OSHA has no authority over safe environments for workers.

153. Defendants acted arbitrarily and capriciously by refusing to provide an exemption to persons with natural immunity to COVID-19 because natural immunity is at least as effective as vaccination in preventing re-infection, transmission, and severe health outcomes.

154. Defendants acted arbitrarily and capriciously by basing its decision to issue the Interim Final Rule under a pretextual justification. *See Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2575 (2019) (setting aside agency action as arbitrary and when "the evidence tells a story that does not match the explanation the Secretary gave for his decision" and "unlike a typical case in which an agency may have both stated and unstated reasons for a decision, here the [] rationale—the sole stated reason—seems to have been contrived."). The true purpose of the vaccine and mask mandate was a political decision and an attempt to federalize public-health issues involving vaccination that belong within the States' police power. According to Defendants,

> The Secretary consulted with experts in child health, including pediatricians, a pediatric infectious disease specialist, and the recommendations of the CDC and FDA. The Secretary considered the Office of Head Start's past experience with the longstanding health and safety Head Start Program Performance Standards that have sought to protect Head Start staff and participants from communicable and contagious diseases. The Secretary also considered the circumstances and challenges typically facing children and families served by Head Start agencies including the disproportionate effect of COVID-19 on low-income communities

> served by Head Start agencies and the potential for devastating consequences for children and families of program closures and service interruptions due to SARS-CoV-2 exposures. The Secretary finds it necessary and appropriate to set health and safety standards for the condition of Head Start facilities that ensure the reduction in transmission of the SARS-CoV-2 and to avoid severe illness, hospitalization, and death among program participants.

86 Fed. Reg. at 68,054. All these supposed reasons are pretextual. The real reason for the Interim Final Rule is because President Biden ordered it. "After the President voiced his displeasure with the country's vaccination ate in September, the Administration pored over the U.S. Code in search of authority, or a 'work-around,' for imposing a national vaccine mandate." *BST Holdings, L.L.C. v. Occupational Safety & Health Admin., United States Dep't of Labor*, 17 F.4th 604, 612 (5th Cir. 2021).

155. Defendants acted arbitrarily and capriciously because their finding that the vaccine mandate is necessary was undermined by its delay in adopting it. Vaccines have been authorized for almost a year, yet Defendants did not impose this mandate until two months after it was instructed to do so by the President as part of his "six-point plan" to federalize public-health policy.

156. The Interim Final Rule is arbitrary and capricious because it mandates that if COVID-19 exists in *some* communities, then *all* communities where Head Start operates must continue universal masking. Staff, volunteers, and students are required to wear masks even if there are no COVID-19 cases in their community. Some Texas counties, such as McMullen, Kenedy, Sterling, and Borden, have not had a reported COVID-19 case in weeks or months.[43] The CDC considers these counties a "low" risk of community transmission of COVID-19.[44] The CDC only

[43] https://covid.cdc.gov/covid-data-tracker/#county-view (last accessed Dec. 8, 2021).
[44] *Id.*

recommends that "unvaccinated people" in these counties "should wear a mask in public, indoor settings."[45] The one-size-fits all interim rule requires staff, volunteers, and students to continue masking regardless of the recommendations by local health officials, and likely long after COVID-19 is no longer present in their communities. There is no end date or criteria for ending the universal mask mandate. So, as long as COVID-19 exists somewhere in the US, everyone in Head Start, regardless of where they are located, their vaccination status, and the conditions on the ground, must continue universal masking.

157. The Interim Final Rule is arbitrary and capricious because Defendants do not know how many staff and volunteers are already vaccinated. This cannot be overstated.

158. Defendants rely on a survey of 1,456 Head Start staff (out of the estimated 820,000 staff and volunteers impacted by the rule), and which included none of the one million volunteers, that was conducted between May and June 2021, and found that 73% of head start staff were vaccinated.[46] The study did not specify whether the respondents were fully or partially vaccinated. Critically, the study concluded that "Overall vaccine uptake among US child care providers [] was significantly higher than that of the US general adult population (65%) at the time of the survey…. Of those reporting having not yet received the COVID-19 vaccine, another 11.9% stated that they were 'absolutely certain' (5.0%) or 'very likely' (6.9%) to get vaccinated in the future, **suggesting**

[45] *Id.*; *but, see* https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-guidance.html (last visited on Dec. 8, 2021) (CDC recommending universal masking in k-12 schools regardless of vaccination status).

[46] Kavin M. Patel, M.D., et. al., *COVID-19 Vaccine Uptake Among US Child Care Providers*, Pediatrics, Nov. 1, 2021, https://publications.aap.org/pediatrics/article/148/5/e2021053813/181547/COVID-19-Vaccine-Uptake-Among-US-Child-Care.

that the final vaccine uptake among child care providers may settle around 90%."[47] The study assumed this vaccination rate would be achieved voluntarily, without a vaccine mandate. Defendants ignored the study's conclusion and *chose to assume* that all of the Head Start respondents in the study were only partially, and not fully, vaccinated. Defendants admit that they have no other data to rely on in determining how many staff and volunteers are currently vaccinated. Similarly, they have no goal to achieve a sufficient number of vaccinations to protect the health and safety of staff and students, short of 100%. Yet, they cite to no data showing that a vaccination rate of 90%—or 80% or—70%—is not sufficient to protect the health and safety of the staff and students.

159. Instead, Defendants extrapolated the number from the study, which showed that Head Start staff were 12% more likely to get vaccinated than the general public. At the time the rule was published, 83.5% of adults were partially vaccinated, and 71.6% of adults were fully vaccinated.[48] If Head Start staff are 12% more likely to get vaccinated, then seemingly when the rule was published, approximately 93.7% of Head Start staff are partially vaccinated and 80.2% are fully vaccinated. Defendants cite to no data showing that this is not a sufficiently high enough vaccination rate to protect students and staff. Instead, Defendants abruptly switch the modeling criteria by factoring in the percentage of adults likely to get vaccinated, whereupon they concluded that 77.9% of Head Start staff are currently vaccinated and this number will only rise to 79.8% by March 1, 2022, without regulatory action. There is no scientific basis for this conclusion.

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[47] *Id.* (emphasis added).

[48] https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-pop18 (last visited Dec. 8, 2021).

160. Defendants are not tracking, and do not actually know, what the vaccination rate among Head Start staff and volunteers. Their reliance on a single survey of 1,456 staff from June 2021 is wholly insufficient to support a sweeping Vaccine Mandate. Even when relying on the survey, Defendants ignored the study's conclusions that 90% of child care workers would voluntarily get vaccinated; instead, coming up with a wholly speculative and pretextual model to achieve their desired outcome. Therefore, the rule is arbitrary and capricious because it is not rationally related to the evidence relied upon.

161. The Interim Final Rule is arbitrary and capricious because Defendants failed to consider conflicting evidence on masking children under 5 years of age. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) specifically advise that "Children aged 5 years and under should not be required to wear masks. This is based on the safety and overall interest of the child and the capacity to appropriately use a mask with minimal assistance."[49] Defendants wholly failed to consider contrary evidence, instead solely relying on the CDC's recommendations.

162. Defendants acted arbitrarily and capriciously by requiring that children ages two years old and older wear masks outdoors. Defendants failed to consider that outdoor transmissions are exceedingly rare.[50] Many experts believe that outdoor masking is misguided.[51] When masks are

[49] https://www.who.int/news-room/questions-and-answers/item/q-a-children-and-masks-related-to-covid-19 (last visited Dec. 8, 2021).

[50] Tim O'Donnell, *Is the CDC exaggerating the risk of outdoor COVID-19 transmission?*, Yahoo News, May 11, 2021, https://www.yahoo.com/entertainment/cdc-exaggerating-risk-outdoor-covid-135958591.html?soc_src=social-sh&soc_trk=ma.

[51] Vinay Prasad, M.D., M.P.H., *The Downsides of Masking Young Students Are Real*, the Atlantic, Sept. 2, 2021, https://www.theatlantic.com/ideas/archive/2021/09/school-mask-mandates-downside/619952/.

required in outdoor settings, kids may experience limitations in play, exercise tolerance, and socialization. In Spain, children six years of age and older are required to wear a mask at school. A recent study of students in the Catalonia region found that transmission rates were lower among unmasked three to five-year-olds compared to masked children over six.[52]

163. Defendants cite *no scientific evidence* that children under five are better protected by masking. The data it relies on all involved adults and older children.

164. The Interim Final Rule is arbitrary and capricious because it failed to consider evidence that doesn't support masking children between the ages of two and five, and it is arbitrary and capricious because it is not rationally related to the evidence relied upon that involved adults and older children.

165. Defendants also acted arbitrarily and capriciously by repeatedly relying on CDC guidelines to justify the Interim Final Rule[53] because CDC Guidelines are merely nonbinding recommendations and have never otherwise been imposed on Head Start programs.

166. The Mask Mandate is arbitrary and capricious because Defendants entirely filed to consider an important aspect of the problem—namely, that many Head Start participants go to school with children who are not in Head Start. Defendants acknowledge that the majority of its participants are from poor families and are disproportionately members of minority communities. 86 Fed. Reg. at 68,055–56. The Mask Mandate essentially means the "poor kids" in Head Start

[52] Alonso, Sergio PhD, et. al., *Age-dependency of the Propagation Rate of Coronavirus Disease 2019 Inside School Bubble Groups in Catalonia, Spain*, The Pediatric Infectious Disease Journal, Nov. 2021, https://journals.lww.com/pidj/Fulltext/2021/11000/Age_dependency_of_the_Propagation_Rate_of.2.aspx.

[53] *See*, *e.g.*, 86 Fed. Reg. at 68,054 at n.28, 30; 68,059 at n.78; 68,060 at n.81.

are stigmatized by having to wear masks, while others in school do not, creating the perception that the Head Start kids are dirty or contagious, and could subject them to playground taunts, ridicule, and isolation, and severely impact their self-esteem. The Mask Mandate is arbitrary and capricious because it failed to consider these psychosocial and developmental impacts.

167. The Mask Mandate is arbitrary and capricious because Defendants entirely failed to consider an important aspect of the problem-namely, the effectiveness of masking in preventing the spread of COVID-19 when mixing masked and unmasked children. In Texas, students who are not in Head Start are not required to wear a mask. Defendants failed to consider whether masking is an effective method of preventing the spread of COVID-19 when masked students are mixed unmasked students.

168. Defendants acted arbitrarily and capriciously by justifying the Mask Mandate with a study that does not justify the Mask Mandate. According to the Interim Final Rule, a "study found that implementing and monitoring adherence to recommended mitigation strategies, such as mask use, can reduce risk for SARS-COV-2 transmission in Head Start settings. It also showed that Head Start and Early Head Start programs that successfully implemented CDC-recommended guidance for childcare programs were able to continue offering safe in-person learning." 86 Fed. Reg. at 68,056. But the study says:

> **Multiple strategies** were implemented simultaneously, including training teachers and encouraging caretakers to adhere to SOPs and mitigation strategies; instituting flexible medical leave policies for staff members; providing and requiring use of masks for all staff members and children; and supervising handwashing and hand-sanitizing for children (Box). **Variations regarding methods for screening the health of staff members and children were noted**; among these methods, self-administered temperature checks upon arrival were most frequently reported for staff members. **Screening for signs and symptoms of illness upon arrival was most frequently reported for children. Mask policies for children varied**, and exemptions for children aged <2 years and those with special health care and education needs were allowed. All programs reported increased

> cleaning and disinfecting or sanitizing of high-traffic areas, high-touch surfaces, and toys. Five programs reported increasing cleaning and disinfecting of bedding and improving ventilation. **Guidance from public health or education agencies and state or local mandates were the factors most commonly reported to influence decisions about SOP adjustments.**… The findings in this report are subject to at least two limitations … study outcomes could not be attributed to implemented mitigation strategies.[54]

This study fails to show that mask use "can reduce risk for [COVID-19] transmission in Head Start settings because "[m]ask policies for children varied." The most common strategy was screening for signs of illness, not mask use. Yet the Interim Final Rule does not allow screening for signs of illness as an alternative to masking.

169. Defendants acted arbitrarily and capriciously by justifying the Mask Mandate with another study that does not justify the Mask Mandate. According to the Interim Final Rule, "[C]ounties without school mask requirements experienced larger increases in pediatric COVID-19 case rates after the start of school compared to counties that had school mask requirements." 86 Fed. Reg. at 86,056. It cites a study[55] which said, "The findings in this report are subject to at least four limitations. First, this was an ecologic study, and causation cannot be inferred. Second, pediatric COVID-19 case counts and rates included all cases in children and adolescents aged <18 years; later analyses will focus on cases in school-age children and adolescents. Third, county-level teacher vaccination rate and school testing data were not controlled for in the analyses; later analyses will control for these covariates. Finally, because of the small sample size of counties

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[54] Coronado F, Blough S, Bergeron D, et al., *Implementing Mitigation Strategies in Early Care and Education Settings for Prevention of SARS-CoV-2 Transmission — Eight States, September–October 2020*, MMWR Morb Mortal Wkly Rep, Dec. 11, 2020, DOI: http://dx.doi.org/10.15585/mmwr.mm6949e3 (emphasis added).

[55] Budzyn SE, Panaggio MJ, Parks SE, et al., *Pediatric COVID-19 Cases in Counties With and Without School Mask Requirements — United States, July 1–September 4, 2021*, MMWR Morb Mortal Wkly Rep 2021, Oct. 1, 2021, DOI: http://dx.doi.org/10.15585/mmwr.mm7039e3.

selected for the analysis, the findings might not be generalizable." 86 Fed. Reg. at 68,056 n.49. This study does not support the Mask Mandate.

170. Even if Defendants were authorized by statute or prior rules to promulgate the Interim Final Rule, which they are not, the Court would still have to set it aside for being arbitrary and capricious. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious [or] an abuse of discretion." 5 U.S.C. § 706(2)(A).

E. The Interim Final Rule was adopted in violation of the notice-and-comment requirement.

171. Defendants must comply with the notice-and-comment requirements of 5 U.S.C. § 553 before promulgating a rule. Subject to certain statutory exceptions not implicated here, a "[g]eneral notice of proposed rulemaking shall be published in the Federal Register." 5 U.S.C. § 553(b). "After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. § 553(c). "The required publication or service of a substantive rule shall be made not less than 30 days before its effective date [with inapplicable exceptions]." 5 U.S.C. § 553(d).

172. Notice-and-comment procedures do not apply "when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(3)(B).

173. The "good cause" exception should be read narrowly and "should not be used to circumvent the notice and comment requirements whenever an agency finds it inconvenient to comply." *U.S. Steel Corp. v. U.S. E.P.A.*, 595 F.2d 207, 214 (5th Cir. 1979). Likewise, the "public

interest" prong only met in "rare circumstances." *Mack Trucks, Inc. v. E.P.A.*, 682 F.3d 87, 89 (D.C. Cir. 2012).

174. Defendants acknowledge that the Interim Final Rule is subject to notice-and-comment requirements, but assert that

> a combination of factors, including but not limited to failure to achieve sufficiently high levels of vaccination based on voluntary efforts and patchwork requirements, potential harm to children from unvaccinated staff, continuing strain on the health care system, and known efficacy and safety of available vaccines, have persuaded us that a vaccine requirement for Head Start staff, certain contractors, and volunteers is an essential component of the nation's COVID-19 response. Further, it would endanger the health and safety of staff, children and families, and be contrary to the public interest to delay imposing the vaccine mandate. Therefore, we believe it would be impracticable and contrary to the public interest for us to undertake normal notice and comment procedures and to thereby delay the effective date of this [Interim Final Rule]. We find good cause to waive notice of proposed rulemaking under the APA.

86 Fed. Reg. at 68,059.

175. Defendants cannot show that notice and comment are impracticable and contrary to the public interest when it waited 82 days from the announcement of the rule on September 9, 2021, until publishing the rule on November 30, 2021. Defendants waited longer to publish the rule without comment than if it had simply noticed the rule and allowed comment.

176. The vaccines have been available for nearly a year, yet until this point, Defendants have sought only to "encourage" vaccination, presumably accepting that not all healthcare workers would choose to be vaccinated. And even when President Biden announced in September that Defendants needed a vaccine mandate, Defendants still waited more than sixty days before taking this emergency action. "Good cause cannot arise as a result of the agency's own delay, because otherwise, an agency unwilling to provide notice or an opportunity to comment could simply wait . . . raise up the 'good cause' banner and promulgate rules without following APA procedures."

Nat. Res. Def. Council v. NHTSA, 894 F.3d 95, 114-15 (2d Cir. 2018). As the Fifth Circuit recently observed with respect to OSHA's two-month delay in issuing its vaccine mandate, "The President announced his intention to impose a national vaccine mandate on September 9, 2021. OSHA issued the Mandate nearly two months later, on November 5, 2021, and the Mandate itself prominently features yet another two-month delay. One could query how an 'emergency' could prompt such a 'deliberate' response. *BST Holdings*, 17 F.4th at 612 n.11 (citation omitted). Although delay is not conclusive, an agency's failure to act promptly is "evidence that a situation is not a true emergency." *Asbestos Info. Ass'n/N. Am. v. Occupational Safety & Health Admin.*, 727 F.2d 415, 423 (5th Cir. 1984).

177. In addition, the notice-and-comment procedures of the Administrative Procedure Act are designed to assure due deliberation. *Smiley v. Citibank (S. Dakota), N.A.*, 517 U.S. 735, 741 (1996). By alleging that notice and comment are "impracticable and contrary to the public interest," Defendants essentially say that, as of November 30, 2021, there is no need for further deliberation. Defendants would have us believe that the science became settled on that date. Millions of Americans and many Head Start programs believe otherwise, as evidenced by the over 1,000 comments that Defendants have already received (but not made available to the public for viewing). The "impracticable and contrary to the public interest" exceptions to notice-and-comment requirements do not apply to this case.

178. If Defendants had the authority to order Head Start staff to get certain medical care, which they do not, natural immunity is one obvious example of an issue that could have benefitted from deliberation. Defendants have not addressed—much less reasonably explained—why natural immunity should not be considered an adequate alternative to vaccination. Nor would it be possible

to reasonably explain away this omission; by all indications, natural immunity confers superior resistance to COVID-19 than any of the currently available vaccines, and one in three Americans had COVID by the end of 2020.[56]

179. Similarly, if Defendants really had the authority they claim, another obvious issue that should be deliberated is testing and other best practices apart from vaccinations. Defendants have not addressed—much less reasonably explained—why other best practices in fighting the spread of COVID-19 could not be used in lieu of vaccination mandates. Nor would it be possible to reasonably explain away this omission; for example, testing has the advantage of providing relative certainty that an individual in the workplace is not infected with COVID-19, whereas vaccination does not provide that guarantee.

180. Because Defendants did not consider these and other issues, Defendants' error in failing to comply with notice-and-comment was not harmless. "[W]hen a party's claims were considered, even if notice was inadequate, the challenging party may not have been prejudiced." *United States v. Johnson*, 632 F.3d 912, 931 (5th Cir. 2011). The flipside is that when claims are not considered, as in this case, prejudice is assumed. "absence of prejudice "must be clear" before applying harmless error. *Id.* at 933.

181. Defendants accept comments until December 30, 2021. 86 Fed. Reg. at 68,052. But "[n]or does accepting post-promulgation comments excuse compliance with APA procedures. We have

[56] *See, e.g.*, Meredith Wadman, *Having SARS-CoV-2 once confers much greater immunity than a vaccine—but vaccination remains vital: Israelis who had an infection were more protected against the Delta coronavirus variant than those who had an already highly effective COVID-19 vaccine*, Science, Aug. 26, 2021, https://www.science.org/content/article/having-sars-cov-2-once-confers-much-greater-immunity-vaccine-vaccination-remains-vital; One in Three Americans Already Had COVID-19 by the End of 2020, (Aug. 26, 2021), https://www.publichealth.columbia.edu/public-health-now/news/one-three-americans-already-had-covid-19-end-2020.

previously found that parties will have a greater opportunity for influencing agency decision making if they participate at an early stage, when the agency is more likely to give real consideration to alternative ideas. If we allowed post-promulgation comments to suffice in this case, we would make the provisions of § 553 virtually unenforceable." *Johnson*, 632 F.3d at 929 (citations omitted).

182. The importance of deliberation is evidenced by the number comments submitted in response to this rule. Currently, in just the week since the rule posted, there are over 1,200 public comments. A critical aspect of rulemaking is both the public and the agency being able to review the public comments submitted about the rule and its impact.

183. At the time of filing, these public comments are not available for the public to view. The reason they are not publicly available is because Head Start has not released them to the Federal Register to publish. This is highly unusual. Typically, public comments are immediately available to view online on the Federal Register website. Perhaps Defendants are deliberately being secretive, or perhaps they are merely taking their time in posting the comments. In either case, the public comments are critical to the court and public in assessing the Interim Final Rule and its impact. The number of comments received by Head Start in just the first week (1,000) exceeds the total number of comments received by OSHA vaccine mandate (441 to date), and vastly exceeds the rate of comments received on the federal contractor vaccine mandate (1,365 to date) and CMS vaccine mandate (1,501 to date), both of which took weeks to reach 1,000 comments. The number and rate of public comments demonstrates the level of public interest and illustrates the importance of going through the notice and comment period before enacting rules.

184. Defendants did not, and could not, demonstrate "good cause" to justify its failure to comply with its notice-and-comment obligations under the APA.

185. For all these reasons, Defendants' promulgation of the Head Start Vaccine Mandate violated APA procedural requirements, and the Head Start Vaccine Mandate should be held unlawful and set aside.

186. Even if Defendants were authorized by statute or prior rules to make the Interim Final Rule, which they are not, the Court would still have to set it aside for failure to comply with notice-and-comment requirements in 5 U.S.C. § 553 without good cause. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

F. The Interim Final Rule is a major rule that was adopted in violation of the Congressional Review Act.

187. "Before a rule can take effect, the Federal agency promulgating such rule shall submit to each House of the Congress and to the Comptroller General a report containing (i) a copy of the rule; (ii) a concise general statement relating to the rule, including whether it is a major rule; and (iii) the proposed effective date of the rule." 5 U.S.C. § 801(a)(1).

188. A "major rule" cannot take effect until at least 60 days after Congress receives the report. 5 U.S.C. § 801(a)(3). A "major rule" is a "rule that the Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget finds has resulted in or is likely to result in an annual effect on the economy of $100,000,000 or more." 5 U.S.C. § 804(2).

189. Defendants acknowledge that "[t]he Office of Information and Regulatory Affairs in the Office of Management and Budget has determined that this action is a major rule because it will have an annual effect on the economy of $100 million or more." 86 Fed. Reg. at 68,063.

190. But "[n]otwithstanding section 801[,] any rule which an agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rule issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest, shall take effect at such time as the Federal agency promulgating the rule determines." 5 U.S.C. § 808(2).

191. Defendants assert that they found

> good cause to waive notice of proposed rulemaking under the APA, 5 U.S.C. 552(d), 553(b)(B). For those same reasons [as found to exempt the Interim Final Rule from notice-and-comment under the APA], . . . we find it is impracticable and contrary to the public interest not to waive the delay in effective date of this [Interim Final Rule] under the [Congressional Review Act]. Therefore, we find there is good cause to waive the [Congressional Review Act's] delay in effective date pursuant to 5 U.S.C. § 808(2).

86 Fed. Reg. at 68,059.

192. For the same reasons that good cause does not exist to exempt the Interim Final Rule from notice-and-comment requirements in the APA, good cause does not exist for Defendants to evoke 5 U.S.C. § 808(2).

193. For the same reasons that skipping notice-and-comment rulemaking was not harmless error, skipping Congressional review was also not harmless error.

194. Even if Defendants were authorized by statute or prior rules to make the Interim Final Rule, which they are not, the Court would still have to set it aside for failure to comply with the Congressional Review Act. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

G. The Interim Final Rule was adopted in violation of 42 U.S.C. § 9836a(a)(2).

195. According to the Interim Final Rule, the vaccine mandate and the mask mandate are "program performance standards" under 42 U.S.C. § 9836a(a)(1). As explained above, they are not. But even if they were, 42 U.S.C. § 9836a(a)(2)(A) requires that, in developing program performance standards, the Secretary "shall consult with experts in the fields of child development, early childhood education, child health care, family services (including linguistically and culturally appropriate services to non-English speaking children and their families), administration, and financial management, and with persons with experience in the operation of Head Start programs."

196. According to the Interim Final Rule, Defendants did not do that. Instead, "[t]he Secretary consulted with experts in child health, including pediatricians, a pediatric infectious disease specialist, and the recommendations of the CDC and FDA." 86 Fed. Reg. at 68,054.

197. Moreover, there is no way to evaluate Defendants' consultations because the agency did not say with whom they met, when they met, for how long, or what they discussed.

198. In addition, 42 U.S.C. § 9836a(a)(2)(B) requires the Secretary to take into consideration ten factors in developing program performance standards. According to the Interim Final Rule,

> [t]he Secretary considered the Office of Head Start's past experience with the longstanding health and safety Head Start Program Performance Standards that have sought to protect Head Start staff and participants from communicable and contagious diseases. The Secretary also considered the circumstances and challenges typically facing children and families served by Head Start agencies including the disproportionate effect of COVID-19 on low-income communities served by Head Start agencies and the potential for devastating consequences for children and families of program closures and service interruptions due to SARS-CoV-2 exposures.

Id. None of these factors that Defendants say they considered are factors that they must consider under § 9836a(a)(2)(B).

199. For instance, § 9836a(a)(2)(B)(vi) requires Defendants to consider "guidelines and standards that promote child health services and physical development, including participation in outdoor activity that supports children's motor development and overall health and nutrition." The Interim Final Rule states, "The Office of Head Start notes that being outdoors with children inherently includes sustained close contact for the purposes of caring for and supervising children." 86 Fed. Reg. at 68,060. Thus, children "participat[ing] in outdoor activity that supports children's motor development" will be required to wear masks. Yet the Interim Final Rule does not discuss how or whether wearing masks during "caring for and supervising children" will affect the beneficial aspects of such activity, in violation of § 9836a(2)(B)(vi).

200. Subsection (a)(2)(C)(2) requires Defendants to "ensure that [the] revisions in the [program performance] standards will not result in the elimination of or any reduction in quality, scope, or types of health, educational, parental involvement, nutritional, social, or other services required to be provided under such standards as in effect on December 12, 2007." No such analysis appears in the Interim Final Rule.

201. Subsection (a)(2)(D) requires Defendants to "consult with Indian tribes, including Alaska Natives, experts in Indian, including Alaska Native, early childhood education and development, linguists, and the National Indian Head Start Directors Association on the review and promulgation of [program performance] standards." The Interim Final Rule contains a "Tribal Consultation Statement" which states,

> [The Administration for Children and Families] conducts an average of five tribal consultations each year for tribes operating Head Start and Early Head Start. The

> consultations are held in four geographic areas across the country: Southwest, Northwest, Midwest (Northern and Southern), and East. The consultations are often held in conjunction with other tribal meetings or conferences, to ensure the opportunity for most of the 150 tribes that operate Head Start and Early Head Start programs to attend and voice their concerns regarding service delivery. We complete a report after each consultation, and then we compile a final report that summarizes the consultations. We submit the report to the Secretary of Health and Human Services (the Secretary) at the end of the year. We invite public comment on this [Interim Final Rule] if there are concerns specific to Native communities and programs.

86 Fed. Reg. at 68,052. In other words, Defendants state only that they meet with Indians once a year. But § 9836a(a)(2)(D) requires consultation with Indians *before* issuing program performance standards, which the Interim Final Rule supposedly contains. It is not enough that Defendants have annual meetings with Indians. Defendants violated 42 U.S.C. § 9836a(a)(2)(D).

202. Defendants' multiple violations of § 9836a(a)(2) require the Interim Final Rule to be set aside. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

H. The Interim Final Rule was adopted in violation of the Treasury and General Government Appropriations Act of 1999.

203. Defendants admit that Section 654 of the Treasury and General Government Appropriations Act of 1999) (codified at 5 U.S.C. § 601 note) requires them to determine whether a policy or regulation may negatively affect family well-being. 86 Fed. Reg. at 68,062.

204. But they summarily dismiss the need for an impact assessment, reasoning "it is not necessary to prepare a family policymaking assessment … because [the rule] will not have any impact on the autonomy or integrity of the family as an institution." *Id.*

205. First, the impact analysis is mandatory. Public Law 105-277, 5 U.S.C. § 601 note ("Before implementing policies and regulations that may affect family well-being, each agency *shall* assess such actions[.]") (emphasis added). Congress specifically required Defendants to include an

impact analysis to assess any impact on family well-being. *Id*. Following Defendants' logic used in this Interim Final Rule, Defendants could subjectively determine that the analysis is not required as they see fit to conveniently circumvent the requirement. This directly undermines the statute and renders the impact analysis requirement moot.

206. Second, an impact analysis has specific requirements that agencies must meet. For example, the impact analysis

> must assess such actions with respect to whether—(1) the action strengthens or erodes the stability or safety of the family and, particularly, the marital commitment;(2) the action strengthens or erodes the authority and rights of parents in the education, nurture, and supervision of their children; (3) the action helps the family perform its functions, or substitutes governmental activity for the function; (4) the action increases or decreases disposable income or poverty of families and children; (5) the proposed benefits of the action justify the financial impact on the family; (6) the action may be carried out by State or local government or by the family; and (7) the action establishes an implicit or explicit policy concerning the relationship between the behavior and personal responsibility of youth, and the norms of society.

5 U.S.C. § 601 note. In addition to the other requirements concerning the impact analysis, Defendants wholly and completely ignored this requirement.[57]

[57] *See also* 5 U.S.C. § 601 note ("(d) Governmentwide family policy coordination and review.--(1) Certification and rationale.--With respect to each proposed policy or regulation that may affect family well-being, the head of each agency shall--(A) submit a written certification to the Director of the Office of Management and Budget and to Congress that such policy or regulation has been assessed in accordance with this section [this note]; and (B) provide an adequate rationale for implementation of each policy or regulation that may negatively affect family well-being. (2) Office of Management and Budget.--The Director of the Office of Management and Budget shall--(A) ensure that policies and regulations proposed by agencies are implemented consistent with this section; and (B) compile, index, and submit annually to the Congress the written certifications received pursuant to paragraph (1)(A). (3) Office of Policy Development.--The Office of Policy Development shall--(A) assess proposed policies and regulations in accordance with this section [this note]; (B) provide evaluations of policies and regulations that may affect family well-being to the Director of the Office of Management and Budget; and (C) advise the President on policy and regulatory actions that may be taken to strengthen the institutions of marriage and family in the United States.").

207. Third, Defendants limit the meaning of "family well-being" in contradiction to the actual text. Assessment of "family well-being" is not defined as an assessment of the impact "on autonomy or integrity of the family as an institution." Instead, it is an assessment of "family well-being" and requires Defendants to assess the statutorily require factors.

208. Defendants failed to comply with this procedural requirement. Under the APA, a court must "hold unlawful and set aside agency action" that is found to be "not in accordance with law" or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A), (D).

I. The Interim Final Rule is an unconstitutional exercise of the Spending Power.

209. If 42 U.S.C. § 9836a(a)(1) authorized Defendants to enforce the Vaccine Mandate and the Mask Mandate, which it does not, then it would be an unconstitutional condition on the receipt of federal funds.

210. "[I]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously," so "States [can] exercise their choice knowingly." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). The executive branch cannot impose conditions on spending that the Constitution would prohibit it from imposing directly, because that authority belongs to Congress. *See id.* at 17. Only *Congress* can condition the receipt of federal funds.

211. 42 U.S.C. § 9836a(a)(1) does not authorize, let alone unambiguously impose, the Vaccine Mandate or the Mask Mandate. There is no nexus between grants to Head Start and vaccine and mask requirements. *South Dakota v. Dole*, 483 U.S. 203 (1987). Thus, the Vaccine Mandate and the Mask Mandate are not authorized under the Spending Clause.

J. The Interim Final Rule violates the Anti-Commandeering Doctrine.

212. "[T]he Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs." *Printz v. United States*, 521 U.S. 898, 925 (1997).

213. Even if the Vaccine Mandate and the Mask Mandate were valid, which they are not, they would unconstitutionally compel LISD and others, such as Texas Tech, to administer a federal regulatory program by forcing them to either fire their unvaccinated employees and fire and expel staff and children who do not wear mask or risk their Head Start funding.[58]

214. Forcing Head Start programs to comply with the Vaccine Mandate and the Mask Mandate under threat of the loss of all funding is unconstitutionally coercive; it is a gun to the head that compels Texas and other governmental entities such as LISD operating Head Start programs to participate against its will. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 580 (2012).

215. For all these reasons, the Interim Final Rule was adopted pursuant to an unconstitutional exercise of authority and must be held unlawful and set aside.

K. The Interim Final Rule violates the Tenth Amendment.

216. The structure of the U.S. Constitution and the text of the Tenth Amendment protect federalism.

217. The powers not delegated by the Constitution to the federal government are reserved to the States.

218. Through the Vaccine Mandate and the Mask Mandate, the federal government seeks to exercise power far beyond what was delegated to the federal government under the United States Constitution.

[58] *See* Exhibit 4.

219. The power to impose vaccine mandates and mask mandates, to the extent that any such power exists, is a power reserved to the States.

220. "[T]he police power of a state" includes, above all, the authority to adopt regulations seeking to "protect the public health," including the topic of mandatory vaccination. *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905). These matters "do not ordinarily concern the national government." *Id*. at 38.

221. By interfering with the traditional balance of power between the States and the federal government, Defendants violated the Tenth Amendment and structural principles of federalism.

222. For all these reasons, the Interim Final Rule was adopted pursuant to an unconstitutional exercise of authority and must be held unlawful and set aside.

VII. CLAIMS FOR RELIEF

223. Plaintiffs incorporate the allegations in each paragraph of this complaint in each following court. To the extent there is any perceived inconsistency, Plaintiffs expressly pleads each count in the alternative.

COUNT 1
The Interim Final Rule Exceeds Statutory Authority and Is Not in Accordance with Law

224. The Interim Final Rule is not authorized by 42 U.S.C. § 9836a(a)(1) or any other statute.

225. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory … authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

226. Defendants did not act in accordance with the law and exceeded their statutory authority when they issued the interim final rule.

227. The Court must set aside the Interim Final Rule.

COUNT 2
The Interim Final Rule is Not a
Mere Extension of Previously Existing Rules

228. To the extent that Defendants claim they are authorized to promulgate the vaccine mandate or the mask mandate by the rules in place before Defendants adopted the Interim Final Rule, they are incorrect.

229. The Vaccine Mandate and the Mask Mandate are neither interpretive rules nor merely informal interpretations of Defendants' own regulations.

230. The Interim Final Rule is not justified by pre-existing rules.

231. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory … authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

232. The Court must set aside the Interim Final Rule.

COUNT 3
Arbitrary and Capricious Agency Action

233. For the reasons described above, the Interim Final Rule is arbitrary and capricious.

234. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary and capricious." 5 U.S.C. § 706(2)(A).

235. The Interim Final Rule is arbitrary and capricious and must be set aside.

COUNT 4
Failure to Conduct Notice and Comment

236. As discussed above, Defendants filed to comply with the notice-and-comment requirements of the APA in promulgating the Interim Final Rule.

237. The Court must set aside the Interim Final Rule for failure to comply with notice-and-comment requirements in 5 U.S.C. § 553. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

COUNT 5
Failure to Comply with the Congressional Review Act

238. As discussed above, Defendants failed to comply with the Congressional Review Act in promulgating the Interim Final Rule.

239. The Court must set aside the Interim Final Rule for failure to comply with the Congressional Review Act. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

COUNT 6
Failure to Comply with 42 U.S.C. § 9836a(a)(2)

240. As discussed above, Defendants failed to comply 42 U.S.C. § 9836a(a)(2) in promulgating the Interim Final Rule.

241. The Court must set aside the Interim Final Rule for failure to comply with 42 U.S.C. § 9836a(a)(2). "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

COUNT 7
Failure to Comply with the Treasury and General Government Appropriations Act of 1999

242. As discussed above, Defendants failed to comply with the Treasury and General Appropriations Act of 1999 in promulgating the Interim Final Rule.

243. The Court must set aside the Interim Final Rule for failure to comply with the Treasury and General Appropriations Act of 1999. "The reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

COUNT 8
Unconstitutional Exercise of Spending Power

244. As discussed above, the Interim Final Rule is an unconstitutional exercise of Spending Power.

245. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory … authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

246. The Court must set aside the Interim Final Rule because it is an unconstitutional exercise of Spending Power. 5 U.S.C. § 706(A), (c).

COUNT 9
Violation of Anti-Commandeering Doctrine

247. As discussed above, the Interim Final Rule unconstitutionally violates the Anti-Commandeering Doctrine.

248. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

249. The Court must set aside the Interim Final Rule because it unconstitutionally violates the Anti-Commandeering Doctrine. 5 U.S.C. § 706(A), (c).

COUNT 10
Violation of the Tenth Amendment

250. As discussed above, the Interim Final Rule violates the Tenth Amendment.

251. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

252. The Court must set aside the Interim Final Rule because violates the Tenth Amendment. 5 U.S.C. § 706(A), (c).

VIII. DECLARATORY JUDGMENT

253. The federal Declaratory Judgment Act authorizes federal courts to declare the rights of litigants. 28 U.S.C. § 2201. The issuance of a declaratory judgment can serve as the basis for an injunction to give effect to the declaratory judgment. *Steffel v. Thompson*, 415 U.S. 452, 461 n. 11 (1974).

254. For the reasons described in each of the previous counts, Plaintiffs are entitled to a declaratory judgment that the Defendants are violating the law and the Interim Final Rule is unlawful, unconstitutional, and unenforceable.

IX. PRAYER FOR RELIEF

For these reasons, Plaintiffs respectfully request that the Court:

i. Hold unlawful and set aside the Interim Final Rule.

ii. Issue declaratory relief declaring the Defendants' actions unlawful.

iii. Issue preliminary and permanent injunctive relief enjoining Defendants from enforcing the Interim Final Rule.

iv. Award such other relief as the Court deems equitable and just.

Respectfully submitted,

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EXHIBIT 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

45 CFR Part 1302

RIN 0970–AC90

Vaccine and Mask Requirements To Mitigate the Spread of COVID–19 in Head Start Programs

AGENCY: Office of Head Start (OHS), Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment (IFC) adds new provisions to the Head Start Program Performance Standards to mitigate the spread of the coronavirus disease 2019 (COVID–19) in Head Start programs. This IFC requires effective upon publication, universal masking for all individuals two years of age and older, with some noted exceptions, and all Head Start staff, contractors whose activities involve contact with or providing direct services to children and families, and volunteers working in classrooms or directly with children to be vaccinated for COVID–19 by January 31, 2022.

DATES:

Effective date: This IFC is effective on November 30, 2021.

Compliance date: The compliance date for the mask requirement is the date of publication of the rule, November 30, 2021. The compliance date for the vaccine requirement is January 31, 2022. For more information, *see* **SUPPLEMENTARY INFORMATION.**

Comment date: To be assured consideration, comments on this interim final rule must be received on or before December 30, 2021.

ADDRESSES: You may submit comments, identified by [docket number and/or RIN number], by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Office of Head Start, Attention: Director of Policy and Planning, 330 C Street SW, 4th Floor, Washington, DC 20201.

Instructions: All submissions received must include the agency name and docket number or RIN for this rulemaking. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Colleen Rathgeb, OHS, at *HeadStart@eclkc.info* or 1–866–763–6481. Deaf and hearing-impaired individuals may call the Federal Dual Party Relay Service at 1–800–877–8339 between 8 a.m. and 7 p.m. Eastern Standard Time.

SUPPLEMENTARY INFORMATION: The compliance date for the vaccine requirement is January 31, 2022. This means *staff, certain contractors and volunteers* must have their second dose in a two-dose series, or first dose in a single-dose by January 31, 2022. Full vaccination requires 14 days after a two-dose series such as Pfizer or Moderna or 14 days after a single-dose series like Johnson & Johnson, but for purposes of this regulation, staff, certain contracts and volunteers will meet the requirement even if they have not yet completed the 14-day waiting period required for full vaccination. This timing flexibility applies only to the initial implementation of this IFC and has no bearing on ongoing compliance.

Table of Contents

I. Tribal Consultation Statement

ACF conducts an average of five tribal consultations each year for tribes operating Head Start and Early Head Start. The consultations are held in four geographic areas across the country: Southwest, Northwest, Midwest (Northern and Southern), and East. The consultations are often held in conjunction with other tribal meetings or conferences, to ensure the opportunity for most of the 150 tribes that operate Head Start and Early Head Start programs to attend and voice their concerns regarding service delivery. We complete a report after each consultation, and then we compile a final report that summarizes the consultations. We submit the report to the Secretary of Health and Human Services (the Secretary) at the end of the year. We invite public comment on this IFC if there are concerns specific to Native communities and programs.

II. Statutory Authority

ACF publishes this interim final rule under the authority granted to the Secretary by sections 641A(a)(1)(C), (D) and (E) of the Head Start Act, 42 U.S.C. 9836a(a)(1)(C)–(E)), (D) and (,), as amended by the Improving Head Start for School Readiness Act of 2007 (Pub. L. 110–134).

III. Executive Summary

A. Purpose of the Interim Final Rule

SARS–CoV–2, the infectious agent that causes COVID–19, is considered to be mainly transmissible through exposure to respiratory droplets when a person is in close contact with someone who has COVID–19. Correct and consistent facemask use has been critical in reducing the risk of droplet transmission of SARS–CoV–2.[1 2] Vaccination is the most important measure for reducing risk for SARS–CoV–2 transmission and in avoiding severe illness, hospitalization, and death.[3]

Four primary variants of SARS–CoV–2 have emerged to date. Of these, the Delta variant has been of particular concern as it causes more infections and spreads faster than other variants.[4] While the Delta variant has increased levels of transmissibility, COVID–19 vaccination remains highly effective against hospitalization and death. Although there are cases of SARS–CoV–2 infections among vaccinated individuals,[5] fully vaccinated adults were six times less likely to become infected, twelve times less likely to be hospitalized and eleven times less likely to die from COVID–19 compared to unvaccinated adults according to data from August 2021.[6 7] While studies are still ongoing, preliminary data suggest that vaccinated persons infected with the Delta variant are potentially less infectious, and infectious for shorter

[1] *https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html.*

[2] *https://www.osha.gov/coronavirus/safework.*

[3] *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html.*

[4] Centers for Disease Control and Prevention. "Delta Variant: What We Know About the Science." August 26, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html.*

[5] Trends in COVID–19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0–17 Years—United States, August 2020–August 2021 | MMWR.

[6] *https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status* MMWR Morb Mortal Wkly Rep 2021;70:1255–1260. DOI: *http://dx.doi.org/10.15585/mmwr.mm7036e2.*

[7] *https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination.*

periods of time compared to infected unvaccinated persons.[8] [9] [10] [11] [12] [13]

The purpose of this IFC is to protect the health and safety of Head Start staff, children, and families and to mitigate the spread of SARS–CoV–2 in Head Start programs. It requires: (1) Universal masking for all individuals two years of age and older, with some noted exceptions, effective immediately upon publication of this rule), (2) vaccination for COVID–19 by January 31, 2022, with some noted exemptions, for all Head Start program staff, inclusive of Head Start, Early Head Start, and Early Head Start-Child Care Partnerships, certain contractors, and volunteers in classrooms or working directly with children (hereafter referred to as "Head Start staff"), and (3) for those granted an exemption to the requirement specified in (2), at least weekly testing for current SARS–CoV–2 infection. The requirements in this IFC will reduce the risk of transmission of SARS–CoV–2 in classrooms, which will protect the health and safety of children, reduce closures of Head Start programs, which can cause hardship for families, and support the Administration's priority of sustained in-person early care and education that is safe for children—with all of its known benefits to children and families.[14]

Greater understanding about the spread of SARS–CoV–2, the increased risk to certain populations, the benefits of masking, and the safety and efficacy of vaccines demonstrates the need for widespread masking and vaccination to reduce COVID–19 and its impacts. Although COVID–19 cases had begun to decline in parts of the country following the most recent COVID–19 surge, data indicate cases are beginning to rise in other parts—particular northern states where the weather has begun to turn colder,[15] and the future trajectory of the pandemic is unclear. The Delta variant is currently the predominant variant in the United States and has resulted in greater rates of cases and hospitalizations among children than from other variants.[16] [17] [18] Furthermore, there is potential for the rapid and unexpected development and spread of additional new and more transmissible variants. Experience with the Delta variant suggests that we must take adequate steps to prevent transmission and protect the workforce and children to avoid serious harm.[19] It is critical that all Head Start staff get fully vaccinated for COVID–19 and consistently wear masks to protect children, staff, and families from exposure to SARS–CoV–2 and to reduce the risk of transmission to families of Head Start children and staff who may be at risk for increased morbidity and mortality from COVID–19.

This IFC adds provisions to the Head Start Program Performance Standards to impose three requirements:

(1) Universal masking, with some noted exceptions, for all individuals two years of age and older when there are two or more individuals in a vehicle owned, leased, or arranged by the Head Start program; when they are indoors in a setting where Head Start services are provided; and, for those not fully vaccinated, outdoors in crowded settings or during activities that involve close contact with other people. This requirement is effective immediately.

(2) Vaccination for COVID–19 for Head Start program staff, certain contractors and volunteers by January 31, 2021.

(3) For those granted an exemption to the requirement specified in (2), at least weekly testing for current SARS–CoV–2 infection.

Being fully vaccinated for COVID–19 and using a mask are two of the most effective mitigation strategies available to reduce transmission of SARS–CoV–2.[20] Additionally, including a regular SARS–CoV–2 testing requirement for those approved for an exemption from the vaccination requirement is necessary to identify infected employees and separate them from the workplace to prevent transmission and to facilitate early medical intervention, when appropriate. Fully vaccinated staff are at much lower risk of infection and therefore, pose lower transmission risk to the young unvaccinated children in their care. The CDC recommends screening testing for current infection of unvaccinated asymptomatic workers as a useful tool to detect SARS–CoV–2 and stop transmission quickly.[21]

B. Interim Final Rule Justification

Section 641A of the Head Start Act authorizes the Secretary to "modify, as necessary, program performance standards by regulation applicable to Head Start agencies and programs," including "administrative and financial management standards," "standards relating to the condition and location of facilities (including indoor air quality assessment standards, where appropriate) for such agencies, and programs," and "such other standards as the Secretary finds to be appropriate," 42 U.S.C. 9836a§ 9836a(a)(1)(C),(D), (E). In developing these modifications, the

[8] Chia PY, Ong SWX, Chiew C, et al. Virological and serological kinetics of SARS–CoV–2 Delta variant vaccine-breakthrough infections: a multi-center cohort study. medRxiv. 2021;*https://www.medrxiv.org/content/10.1101/2021.07.28.21261295v1.*

[9] Shamier MC, Tostmann A, Bogers S. Virological characteristics of SARS–CoV–2 vaccine breakthrough infections in health care workers. medRxiv. 2021;*https://www.medrxiv.org/content/10.1101/2021.08.20.21262158v1.*

[10] Kang M, Xin H, Yuan J. Transmission dynamics and epidemiological characteristics of Delta variant infections in China. medRxiv. 2021;*https://www.medrxiv.org/content/10.1101/2021.08.12.21261991v1.*

[11] Ong SWX, Chiew CJ, Ang LW, et al. Clinical and Virological Features of SARS-CoV–2 Variants of Concern: A Retrospective Cohort Study Comparing B.1.1.7 (Alpha), B.1.315 (Beta), and B.1.617.2 (Delta). Preprints with The Lancet. 2021;*https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3861566.*

[12] Mlcochova P KS, Dhar MS, et al. . SARS–CoV–2 B.1.617.2 Delta variant emergence and vaccine breakthrough. Research Square. 2021 *https://www.researchsquare.com/article/rs-637724/v1.*

[13] *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html*

[14] Barr, A.C., & Gibbs, C. (2019). *Breaking the Cycle? Intergenerational Effects of an Anti-Poverty Program in Early Childhood.* EdWorkingPaper: 19–141. Retrieved from Annenberg Institute at Brown University, *https://edworkingpapers.com/sites/default/files/ai19-141.pdf.*; Bauer, L., & Schanzenbach, D.W. (2016). *The Long-Term Impact of the Head Start Program.* Washington, DC: The Brookings Institute. Retrieved from: *https://www.hamiltonproject.org/assets/files/long_term_impact_of_head_start_program.pdf.*; Ludwig, J., & Phillips, D. (2007). The Benefits and Costs of Head Start. *Social Policy Report, Vol. 21*(3), Society for Research in Child Development. Retrieved from: *https://files.eric.ed.gov/fulltext/ED521701.pdf.*; Garcia, J.L., Heckman, J.J., Leaf, D.E., & Prados M.J. (2019). Quantifying the Life-cycle Benefits of a Prototypical Early Childhood Program. National Bureau of Economic Research Working Paper No. 23479. Cambridge, MA: NBER. Retrieved from: *https://heckmanequation.org/www/assets/2017/01/w23479.pdf.*; Yoshikawa, H., Weiland, C., Brooks-Gunn, J., Burchinal, M.R., Espinosa, L.M., Gormley, W.T., Ludwig, J., Magnuson, K.A., Phillips, D., & Zaslow, M. (2013). *Investing in Our Future: The Evidence Base on Preschool Education.* Society for Research in Child Development and Foundation for Child Development. Retrieved from: *http://www.fcd-us.org/assets/2013/10/Evidence20Base20on20Preschool20Education20FINAL.pdf.*

[15] *https://covid.cdc.gov/covid-data-tracker/#trends_dailycases.*

[16] Delahoy, M., et al. Hospitalizations Associated with COVID–19 Among Children and Adolescents—COVID–Net, 14 States, March 1, 2020—August 14, 2021. *https://www.cdc.gov/mmwr/volumes/70/wr/mm7036e2.htm.*

[17] Siegel DA, Reses HE, Cool AJ, et al. Trends in COVID–19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0–17 Years—United States, August 2020—August 2021.

[18] *https://covid.cdc.gov/covid-data-tracker/#demographicsovertime.*

[19] Centers for Disease Control and Prevention. "Delta Variant: What We Know About the Science." August 26, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html.*

[20] Centers for Disease Control and Prevention. "Science Brief: COVID–19 Vaccines and Vaccination." September 15, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html#:~:text=Evidence%20suggests%20the%20US%20COVID,interrupting%20chains%20of%20transmission.*

[21] Centers for Disease Control. "Overview of Testing for SARS–CoV–2 (COVID–19)" October 22, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html.*

Secretary included relevant considerations pursuant to section 641A(a)(2) of the Head Start Act, 42 U.S.C. 9836a(a)(2). The Secretary consulted with experts in child health, including pediatricians, a pediatric infectious disease specialist, and the recommendations of the CDC and FDA. The Secretary considered the Office of Head Start's past experience with the longstanding health and safety Head Start Program Performance Standards that have sought to protect Head Start staff and participants from communicable and contagious diseases. The Secretary also considered the circumstances and challenges typically facing children and families served by Head Start agencies including the disproportionate effect of COVID–19 on low-income communities served by Head Start agencies and the potential for devastating consequences for children and families of program closures and service interruptions due to SARS–CoV–2 exposures. The Secretary finds it necessary and appropriate to set health and safety standards for the condition of Head Start facilities that ensure the reduction in transmission of the SARS–CoV–2 and to avoid severe illness, hospitalization, and death among program participants.

ACF initially chose, among other actions, to allow Head Start programs to decide whether or not to require staff vaccination rather than require vaccination, to provide information on the COVID–19 vaccine through its Early Childhood Learning and Knowledge Center,[22] the website used to share guidance and information with Head Start grant recipients, and to emphasize that grant recipients can use COVID–19 response funds and American Rescue Plan funds to support staff in getting the COVID–19 vaccine. However, despite all of these efforts, uptake of vaccination among Head Start staff has not been as robust as hoped for and has been insufficient to create a safe environment for children and families. This is particularly true given the advent of the Delta variant and the potential for new variants and as programs continue to return to fully in-person services as the Office of Head Start expects in January 2022. The Office of Head Start (OHS) issued guidance to programs on May 20, 2021 outlining its expectations for programs in the 2021–2022 program year. This guidance prepared programs for the resumption of in-person services and informed programs that they should build toward full enrollment and provide comprehensive services for all enrolled children as soon as possible. It noted that beginning January 2022, OHS intends to reinstate pre-pandemic practices for tracking and monitoring enrollment. OHS will also resume evaluating which programs enter into the Full Enrollment Initiative in January 2022, which is a process by which OHS identifies programs that are not serving their full funded enrollment. This guidance followed a period since the onset of the pandemic of greater flexibility for programs with requirements related to enrollment, service duration, virtual/remote delivery of services, among others. These flexibilities were critical to programs' ability to continue providing services to children and families and to adapt services based on the changing health conditions in their communities during unprecedented times. As programs prepare for fully in-person services, it is imperative that we create conditions that support the health and safety of children and reduce program closures and service interruptions. The universal masking and vaccination requirements outlined in this IFC are critical to this effort.

The U.S. Centers for Disease Control and Prevention (CDC) issued guidance July 27, 2021.[23] The CDC stated that the rationale for this guidance was twofold: (1) An alarming rise in COVID–19 cases and hospitalization rates around the country—a reversal in what had been a steady decline since January 2021[24] and (2) new data showing the Delta variant to be highly transmissible.[25] A study covering the period from June to mid-August 2021 showed that weekly COVID–19 associated hospitalization rates among children and adolescents rose nearly five-fold during the late June to mid-August 2021 period, which coincided with increased circulation of the Delta variant.[26] In this same study, hospitalization rates were 10 times higher among unvaccinated than fully vaccinated adolescents. A separate study conducted in the United Kingdom showed that vaccination effectively reduces the risk of Delta variant infection[27] but that "vaccination alone is not sufficient to prevent all transmission of the delta variant in the household setting, where exposure is close and prolonged." The authors recommended nonpharmaceutical interventions, such as mask wearing, as an important complementary approach alongside vaccination to minimize spread of the Delta variant.

On November 10, 2021, the CDC issued updated guidance to early childhood education and child care (ECE) programs.[28] One of the key changes in the guidance is the recommendation for universal indoor masking for ECE programs for everyone aged 2 years and older regardless of vaccination status, with limited exceptions, see section V *Provisions of the Interim Final Rule*. It also notes that ECE program staff can model consistent and correct use for children aged 2 years or older in their care. Vaccinations and masks are key strategies for reducing the transmission of SARS–CoV–2 along with other risk reduction strategies, including staying home if sick; handwashing; improving ventilation; screening and diagnostic testing, cleaning, and disinfecting; keeping physical distance; and cohorting,[29] especially because physical distancing is not always feasible in early childhood settings.[30]

The COVID–19 vaccines are the safest and most effective way to protect individuals and the people with whom they live and work from infection and

[22] Office of Head Start. "OHS COVID–19 Updates." Available at: *https://eclkc.ohs.acf.hhs.gov/about-us/coronavirus/ohs-covid-19-updates.*

[23] *Centers for Disease Control and Prevention. "Science Brief: COVID–19 Vaccines and Vaccination." September 15, 2021. Available at: https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html#:~:text=Evidence%20suggests%20the%20US%20COVID,interrupting%20chains%20of%20transmission.*

[24] Centers for Disease Control and Prevention. "COVID Data Tracker." Available at: *https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalization-network.*

[25] Brown CM, Vostok J, Johnson H, et al. Outbreak of SARS–CoV–2 Infections, Including COVID–19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings—Barnstable County, Massachusetts, July 2021. MMWR Morb Mortal Wkly Rep. ePub: 30 July 2021; *https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm.*

[26] Delahoy MJ, Ujamaa D, Whitaker M, et al. Hospitalizations Associated with COVID–19 Among Children and Adolescents—COVID–NET, 14 States, March 1, 2020–August 14, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1255–1260. DOI: *http://dx.doi.org/10.15585/mmwr.mm7036e2.*

[27] Singanayagam, AnikaBadhan, Anjna et al. Community transmission and viral load kinetics of the SARS–CoV–2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. *https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00648-4/fulltext.*

[28] Centers for Disease Control. "COVID–19 Guidance for Operating Early Care and Education/Child Care Programs." November 10, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/child-care-guidance.html.*

[29] Cohorting refers to placing children and child care providers into distinct groups who stay together throughout an entire day.

[30] Centers for Disease Control and Prevention. "COVID–19 Guidance for Operating Early Care and Education/Child Care Programs." August 25, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/child-care-guidance.html; https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/transmission_k_12_schools.html.*

from severe illness and hospitalization if they contract the virus. Data from August 2021 indicate that when compared with vaccinated adults, those who were not fully vaccinated were 6 times more likely to become infected, 12 times more likely to be hospitalized, and 11 times more likely to die of COVID–19.[31] [32] In addition to preventing morbidity and mortality associated with COVID–19, currently available vaccines also demonstrate effectiveness against asymptomatic SARS–CoV–2 infection. A study of the period from December 14, 2020 to August 14, 2021, found that full vaccination for COVID–19 was 80 percent effective in preventing SARS–CoV–2 infection among health care workers.[33] While the scientific evidence for transmissibility of breakthrough cases (*i.e.,* cases in fully vaccinated individuals) is still developing, fully vaccinated individuals are less likely to spread COVID–19 because they are less likely to become infected in the first place. Studies have shown that vaccinations reduce the risk of COVID–19 among unvaccinated close contacts, including children. For example, one study found that vaccination of health care workers was associated with decreased COVID–19 cases among members of their household.[34] Additionally, a study during the early months of the COVID–19 vaccine rollout in Israel found that community vaccination rates were associated with declines in infections among unvaccinated children.[35] Vaccination was also shown to be effective in lowering the risk of severe disease if infected with the Delta variant, which has emerged as a more contagious strain of the SARS–CoV–2 with a higher impact on children than previous variants.[36]

Given that children under age 5 years are too young to be vaccinated at this time, requiring masking and vaccination among everyone who is eligible are the best defenses against COVID–19, especially cases arising from the more infectious Delta variant. These measures will also reduce program closures due to SARS–CoV–2 infection. When children or staff test positive for SARS–CoV–2 or have exposure to someone else who has tested positive for SARS–CoV–2, classrooms or entire programs close for a period of days or weeks to allow for test results and quarantining per local health department guidance. Additionally, as discussed later in this IFC, closures impose hardship on Head Start children and families by diminishing the ability to attend Head Start in person. The result is harm to early learning and development. Closures also diminish the ability of parents to work or participate in schooling.

Health and Safety

The Delta variant, which in the summer of 2021 became the predominant SARS–CoV–2 strain in the United States, is more contagious—spreading twice as fast—and results in more cases and hospitalizations for children.[37] The increase in hospitalization is more acute in states with lower vaccination rates. Studies released by CDC found that the rate of hospitalization for children was nearly four times higher in states with the lowest vaccination rates when compared to states with high vaccination rates.[38] Furthermore, hospitalization rates for children in September and October 2021, while lower than other age groups, were elevated relative to other periods during the pandemic.[39] Vaccination remains the best line of defense against COVID–19. Data show fully vaccinated persons are less likely than unvaccinated persons to become infected with SARS–CoV–2, and infections with the Delta variant in fully vaccinated persons are associated with less severe clinical outcomes.[40] Being fully vaccinated reduces risk of the transmission of SARS–COV–2 from staff to children who are not yet eligible for the vaccine and must be protected to minimize their exposure. Reducing transmission from staff to children and between staff also reduces transmission from children and staff to their family members. Transmission of SARS–CoV–2 in child care settings has been linked to infections and hospitalizations in family members,[41] and some children and staff may return home to family members who are older or have underlying medical conditions that put them at greater risk for COVID–19-related morbidity and mortality. Studies have shown that COVID–19 has disproportionately affected some racial and ethnic minority groups such as Hispanic or Latino, Black or African American, American Indian or Alaskan Native (AIAN), and Native Hawaiian and other Pacific Islander people.[42] It is also estimated that these disparities may have long term implications for these populations: for example, it is estimated that COVID–19 morbidity and mortality impacts can reverse over 10 years of progress in reducing the gaps in life expectancy between Black and White populations.[43] Many families of Head

[31] Monitoring Incidence of COVID–19 Cases, Hospitalizations, and Deaths, by Vaccination Status—13 U.S. Jurisdictions, April 4–July 17, 2021 Early Release/September 10, 2021/70.

[32] Center for Disease Control and Prevention. "COVID Data Tracker." Available at: *https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination.*

[33] Fowles, A., Gaglani, M., Groover, K., et al. Effectiveness of COVID–19 Vaccines in Preventing SARS–CoV–2 Infection among Frontline Workers Before and During B.1.617.2 (Delta) Variant Predominance—Eight U.S. Locations, December 2020–August 2021. *Morbidity and Mortality Weekly Report.* August 27, 2021, Available at: *https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e4.htm?s_cid=mm7034e4_w.*

[34] Effect of Vaccination on Transmission of SARS–CoV–2. N Engl J Med 2021; 385:1718–1720 DOI: 10.1056/NEJMc2106757.

[35] Milman, O., Yelin, I., Aharony, N. et al. Community-level evidence for SARS–CoV–2 vaccine protection of unvaccinated individuals. Nat Med 27, 1367–1369 (2021). *https://doi.org/10.1038/s41591-021-01407-5.*

[36] Centers for Disease Control and Prevention. "COVID Data Tracker. Pediatric Data." Available at: *https://covid.cdc.gov/covid-data-tracker/#pediatric-data*; Centers for Disease Control and Prevention. "Delta Variant: What We Know About the Science." Available at: *https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html*; Centers for Disease Control and Prevention. Trends in COVID–19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0–17 Years—United States, August 2020–August 2021. Available at: *https://www.cdc.gov/mmwr/volumes/70/wr/mm7036e1.htm?s_cid=mm7036e1_w.*

[37] Centers for Disease Control and Prevention. "Delta Variant: What We Know About the Science." August 26, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html*; *https://covid.cdc.gov/covid-data-tracker/#pediatric-data.*

[38] Siegel DA, Reses HE, Cool AJ, et al. Trends in COVID–19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0–17 Years—United States, August 2020–August 2021. MMWR Morb Mortal Wkly Rep 2021; 70:1249–1254. DOI: *https://www.cdc.gov/mmwr/volumes/70/wr/mm7036e1.htm.*

[39] Centers for Disease Control and Prevention. "COVID Tracker Weekly Review." Available at: *https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html.*

[40] Centers for Disease Control and Prevention. "Science Brief: COVID–19 Vaccines and Vaccination." September 15, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html#:~:text=Evidence%20suggests%20the%20US%20COVID,interrupting%20chains%20of%20transmission.*

[41] Lopez AS, Hill M, Antezano J, et al. Transmission Dynamics of COVID–19 Outbreaks Associated with Child Care Facilities — Salt Lake City, Utah, April–July 2020. MMWR Morb Mortal Wkly Rep 2020;69:1319–1323. DOI: *http://dx.doi.org/10.15585/mmwr.mm6937e3.*

[42] Centers for Disease Control and Prevention. "Introduction to COVID–19 Racial and Ethnic Health Disparities." December 10, 2020. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html.*

[43] Andrasfay, T., & Goldman, N. (2021). Reductions in 2020 US life expectancy due to COVID–19 and the disproportionate impact on the Black and Latino populations. Proceedings of the

Continued

Start children and staff are members of minority communities; 71 percent of families, and 69 percent of staff, self-identify as Hispanic/Latino, Black/African American, American Indian, or Alaska Native,[44] who have been shown to be at increased risk of exposure to SARS–CoV–2. Given the disproportionate burden of COVID–19 deaths and lower vaccination rates among racial and ethnic minority groups, requiring vaccination among Head Start staff is not only an issue of personal health, but also promotes public and community health and health equity for children and staff in Head Start programs.[45]A recent CDC study showed that during the period from May 23 to June 12, 2021, 50 percent of the children in a classroom tested positive for SARS–COV–2 infection in a Marin County, California elementary school following exposure to one unvaccinated teacher.[46] This outbreak, which began with an unvaccinated teacher who attended school for two days with symptoms and took off her mask when reading to the class, demonstrates the importance of vaccinating staff members who work closely with young children. The rate of SARS–CoV–2 positivity in the two rows closest to the teacher's desk was 80 percent (8 of 10); in the three back rows, it was 29 percent (4 of 14). Four days after the teacher reported being symptomatic, when the teacher received a positive test, additional cases of COVID–19 were reported among other staff members, students, parents, and siblings connected to the school. In addition to highlighting the importance of vaccination and masking, this study points to the Delta variant's increased transmissibility and potential for rapid spread, especially in unvaccinated populations such as children too young for vaccination.[47]

Additionally, a study covering the period from July 15 to August 31, 2021, that included public K–12 schools in Maricopa and Pima Counties, Arizona, found that schools without mask requirements were 3.5 times more likely to have COVID–19 outbreaks compared with schools that started the year with mask requirements.[48] This finding is consistent with another study that included 520 counties across the United States during the period July 1 to September 4, 2021, reporting that counties without school mask requirements experienced larger increases in pediatric COVID–19 case rates after the start of school compared to counties that had school mask requirements.[49]

Prior to the availability of COVID–19 vaccines in the United States, during the period from September to October 2020, ACF collaborated with CDC to conduct a mixed-methods study in Head Start programs in eight states (Alaska, Georgia, Idaho, Maine, Missouri, Texas, Washington, and Wisconsin). The study found that implementing and monitoring adherence to recommended mitigation strategies, such as mask use, can reduce risk for SARS–COV–2 transmission in Head Start settings. It also showed that Head Start and Early Head Start programs that successfully implemented CDC-recommended guidance for childcare programs were able to continue offering safe in-person learning.[50]

A survey of the U.S. child care workforce conducted between May 26 and June 23, 2021, found that the overall COVID–19 vaccine uptake among child care providers was 78.2 percent, which was higher than the general U.S. adult population (65 percent).[51] The rate among Head Start and Early Head Start staff in center-based settings specifically was 73 percent, though lower in home-based programs. That 73 percent is a nationwide figure. It could be much less in certain areas. Also, it is 73 percent of adults, but none of the children in the programs can be vaccinated. While other teachers and staff members might be protected from an unvaccinated staff, the concern remains the protection of children and families. Depending on the role in the program of the 27 percent of Head Start staff that are unvaccinated, it could result in roughly 250,000 children who are in the care of an unvaccinated adult. This IFC is critical in order to increase that percentage, given the importance of protecting young children from exposure to SARS–CoV–2, including more transmissible variants.

Data show COVID–19 vaccination requirements are effective in increasing vaccination rates among employees. Other industries that have implemented vaccine requirements have seen substantial increases in the percent of their workforce receiving the vaccine.[52] [53] Two weeks following the Governor of Washington's vaccine requirement for State workers, according to the Washington State Department of Health, the weekly vaccination rate increased 34 percent.[54]

Reduced Program Closures

Requiring staff to get fully vaccinated for COVID–19 is critical to reduce program closures due to SARS–CoV–2 exposures. Such closures may impose multiple hardships on Head Start children and families. The children and families served by Head Start are largely comprised of individuals who experience economic hardship and have been historically underserved and marginalized. In 2019, 80 percent of children served by Head Start were

National Academy of Sciences of the United States of America, 118(5), e2014746118. *https://doi.org/10.1073/pnas.2014746118.*

[44] United States Department of Health and Human Services. "Head Start Program Information Report." Available at: *https://eclkc.ohs.acf.hhs.gov/data-ongoing-monitoring/article/program-information-report-pir.*

[45] Patel KM, Malik AA, Lee A, et al. COVID–19 vaccine uptake among US child care providers. *Pediatrics.* 2021; doi: *https://pubmed.ncbi.nlm.nih.gov/34452977/.*

[46] Lam-Hine T, McCurdy SA, Santora L, et al. Outbreak Associated with SARS–CoV–2 B.1.617.2 (Delta) Variant in an Elementary School—Marin County, California, May–June 2021. MMWR Morb Mortal Wkly Rep 2021; 70:1214–1219. DOI: *http://dx.doi.org/10.15585/mmwr.mm7035e2.*

[47] Lam-Hine T, McCurdy SA, Santora L, et al. Outbreak Associated with SARS–CoV–2 B.1.617.2 (Delta) Variant in an Elementary School—Marin County, California, May–June 2021. MMWR Morb Mortal Wkly Rep 2021; 70:1214–1219. DOI: *http://dx.doi.org/10.15585/mmwr.mm7035e2.*

[48] John M, McCullough JM, Dale AP, et al. Association Between K–12 School Mask Policies and School-Associated COVID–19 Outbreaks—Maricopa and Pima Counties, Arizona, July–August 2021. MMWR Morb Mortal Wkly Rep 2021;70:1372–1373. DOI: *http://dx.doi.org/10.15585/mmwr.mm7039e1.*

[49] Budzyn SE, Panaggio MJ, Parks SE, et al. Pediatric COVID–19 Cases in Counties With and Without School Mask Requirements—United States, July 1–September 4, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1377–1378. DOI: *http://dx.doi.org/10.15585/mmwr.mm7039e3.*

[50] Coronado F, Blough S, Bergeron D, et al. Implementing Mitigation Strategies in Early Care and Education Settings for Prevention of SARS–CoV–2 Transmission—Eight States, September–October 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1868–1872. DOI: *http://dx.doi.org/10.15585/mmwr.mm6949e3.*

[51] Patel KM, Malik AA, Lee A, et al. COVID–19 vaccine uptake among US child care providers. Pediatrics. 2021; doi: *https://www.cdc.gov/mmwr/volumes/70/wr/mm7036e1.htm.*

[52] Hirsch, L. (2021, September 30). *After mandate, 91% of Tyson workers are vaccinated.* The New York Times. Retrieved November 3, 2021, from *https://www.nytimes.com/2021/09/30/business/tyson-foods-vaccination-mandate-rate.html*; Josephs, L. (2021, September 29). Nearly 600 United Airlines employees face termination for failing to comply with Vaccine Mandate. CNBC. Retrieved November 3, 2021, from *https://www.cnbc.com/2021/09/28/unvaccinated-united-airlines-staff-faces-termination-as-early-as-today.html.*

[53] White House. "WHITE HOUSE REPORT: Vaccination Requirements Are Helping Vaccinate More People, Protect Americans from COVID–19, and Strengthen the Economy." Available at: *https://www.whitehouse.gov/wp-content/uploads/2021/10/Vaccination-Requirements-Report.pdf.*

[54] White House. "Path Out of the Pandemic." Available at: *https://www.whitehouse.gov/covidplan/#schools*; Mikkelsen, D. (2021, August 27). *Covid–19 vaccinations increase in Washington following mandates, Spike in cases.* king5.com. Retrieved November 3, 2021, from *https://www.king5.com/article/news/local/covid-19-vaccinations-increase-in-washington/281-1af1cc43-2d7f-4e77-a2fd-0fad28d0c4f3.*

Black, Indigenous, or persons of color.[55] Thirty-eight percent of children were dual language learners, with a language other than English spoken in the home (sometimes in addition to English). The mean annual household income for families was $26,000. Fifty-nine percent of children had a mother with a high school diploma or less, and the majority (77 percent) had a mother who was either working full-time, working part-time, or looking for work. Fifty-seven percent and 52 percent of children's families received SNAP benefits and WIC benefits, respectively. Thirty-one percent of children lived in a household where parents reported household food would often or sometimes run out and they did not have money to purchase more. Twenty-four percent of children's mothers had moderate or severe depressive symptoms, as measured by a clinical depression screening tool.

Head Start programs provide critical services to meet the health, nutrition, and early learning needs of these children and families. Programs provide healthy nutritious meals to children and provide diapers for babies and toddlers, every day they are at the program. Programs ensure children are brushing their teeth and provide critical mental health services. Programs also provide high-quality early education services to promote the overall learning and development of children and prepare them for entry into kindergarten. If a program must close its facilities for a designated period of time due to an outbreak of SARS–CoV–2 infections, children at-risk will not receive these critical in-person services. Further, program closures limit the ability of Head Start families to work or seek educational opportunities. As summarized previously, Head Start families earning low wages and very likely do not have sick leave to care for children while they are in quarantine. Staying home for intermittent closures, rather than working, imposes significant financial costs on Head Start families. It also places the families at risk of losing their employment if they must take unpaid leave to care for children in quarantine. Families rely on Head Start programs to provide stable and reliable early care and education services to their children, and the effects of intermittent closures are significant.

As alluded to previously, program closures also create instability and stress for children and families. They disrupt children's opportunities for learning, socialization, nutrition, and continuity and routine. In June 2020, the Defending the Early Years organization released a survey to better understand the impact COVID–19 has had on young children, their families, and their teachers. Balancing working from home and supporting children was the number one challenge for parents. This challenge was especially acute for families with multiple children in different grade levels or with one child under the age of four years. Fifty-five percent of parents of young children reported they were somewhat-to-very concerned about financial issues (*e.g.,* job loss) due to the COVID–19 pandemic.[56] Other issues of concern related to early childhood education program and school closures and/or virtual or remote learning have compounded to create uniquely difficult challenges for families. These compounding issues include missed opportunities for academic instruction, children falling behind, children missing out on social interaction and play with peers, challenges to safe reopening, and increase in children's stress.

Survey data from February 2021 indicates that a diminished ability to attend early childhood programs like Head Start in-person, is related to an increase in social and emotional difficulties for children, a decrease in support for children with disabilities, and an increase in parental stress due to lack of affordable child care including loss of jobs and wages.[57] The RAPID–EC Survey describes this as a "chain of hardship" where families loss of jobs results in difficulty paying for basic needs such as food and housing further negatively impacting family well-being including a rise in emotional distress for parents and children.[58] These disruptions can be particularly difficult for children and families experiencing homelessness, a population Head Start programs are required to prioritize (45 CFR 1302.15(c)). Of all families enrolled in Head Start programs, about 6.2 percent or 42,334 families experienced homelessness during the 2020–2021 program year.[59] Given the greater risks to the health and development of young children experiencing homelessness, stable Head Start services are critically important for these families.[60]

School closures, heightened stress, loss of income, and social isolation resulting from the COVID–19 pandemic are all stressors that have increased the risk for child abuse and neglect.[61] Head Start programs are required to prioritize foster children for enrollment, and there was an increase in the rate of children in foster care served in Head Start from 3.5 percent in 2019 to 3.8 percent in 2021. Program closures and remote learning during the pandemic contribute to disruption of service access for these children, who often experience trauma and are most in need of the consistent care, education and comprehensive services that Head Start provides.[62]

Supporting safe and sustained in-person services allows programs to return to fulfilling the critical functions they serve for children and families. All Head Start staff are mandated reporters and programs must have internal procedures in place for staff to report suspected cases of child abuse and neglect. Procedures also include notification to the program's Regional Office immediately if a staff member or volunteer suspects an incident. Agencies must provide training in methods for identifying and reporting suspected child abuse and neglect (45

[55] All descriptive statistics in this paragraph are from: Kopack Klein, A., Aikens, N., Li, A., Bernstein, S. Reid, N., Dang, M., Blesson, E. . . . Tarullo, L. (2021). Descriptive Data on Head Start Children and Families from FACES 2019: Fall 2019 Data Tables and Study Design, OPRE Report 2021–77, Washington, DC: U.S. Department of Health and Human Services.

[56] Jones, Denisha. Education Resources Information Center. "The Impact of COVID–19 on Young Children, Families, and Teachers." *Defending the Early Years* (2020). Available at: *https://eric.ed.gov/?id=ED609168.*

[57] Barnett, W.S & Jung, K. Seven Impacts of the Pandemic on Young Children and their Parents: Initial Findings from NIEER's December 2020 Preschool Learning Activities Survey. February 2021. Available at: *NIEER_Seven_Impacts_of_the_Pandemic_on_Young_Children_and_their_Parents.pdf.*

[58] Fisher, P. Lombardi, J. & Kendall Taylor, N. A day in the life of a pandemic/ *https://medium.com/rapid-ec-project/a-year-in-the-life-of-a-pandemic-4c8324dda56b.*

[59] United States Department of Health and Human Services. "Head Start Program Information Report." Available at: *https://eclkc.ohs.acf.hhs.gov/data-ongoing-monitoring/article/program-information-report-pir.*

[60] Kiersten: Coughlin, C.G., Sandel, M., & Stewart, A.M. (2020). Homelessness, Children, and COVID–19: A Looming Crisis. *Pediatrics.* 146(2). Available at: *https://doi.org/10.1542/peds.2020-1408;* Haskett, M.E., Armstrong, J.M., & Tisdale, J. (2016). Developmental Status and Social-Emotional Functioning of Young Children Experiencing Homelessness. Early Childhood Education Journal. 44(2). 119–125. Available at: *https://doi.org/10.1007/s10643-015-0691-8;* Weinreb; L., Goldberg, R., Bassuk, E., & Perloff, J. (1998). Determinants of Health and Service Use Patterns in Homeless and Low-income Housed Children. Pediatrics, 102(3), 554–562. Available at: *https://doi.org/10.1542/peds.102.3.554.*

[61] Rodriguez, C.M, Lee, S.J., Ward, K.P., & Pu, D.F. (2021). The Perfect Storm: Hidden risk of child maltreatment during the Covid–19 pandemic. Child Maltreatment, 26(2), 139–151.

[62] Kiersten: Klain, E.J., & White, A.R. (2013). Implementing trauma-informed practices in child welfare. CITY: State Policy Advocacy Reform Center. Retrieved from *http://www.centerforchildwelfare.org/kb/TraumaInformedCare/ImplementingTraumaInformedPractices Nov13.pdf.*

CFR 1304.52(l)(3)(i)).[63] Research also indicates that Early Head Start can serve as a child abuse and neglect prevention program.[64] The work Head Start programs do to strengthen family economic stability and decrease parental stressors is known to help prevent child abuse. Many programs also provide supports to families experiencing domestic violence (2.5 percent or 24,000 families in 2019 OHS data [65]). This IFC is an important step in decreasing serious risks to very young children and their families.

OHS has been tracking data on the operating status of programs since the onset of the pandemic. In March and April of 2020, more than 90 percent of programs closed all in-person operations for varying lengths of time. By August of 2020, 21 percent of programs had reopened for in-person services, 26 percent remained closed for in-person services due to COVID–19, and the remainder of programs were closed for summer months as regularly scheduled. In December 2020, data show the highest combined percentage (67 percent) of Head Start centers operating as solely virtual/remote or as hybrid, with an additional five percent, or 878, of centers closed. Together, these virtual/remote, hybrid, and closed centers account for over 13,500 centers nationwide. Each center represents many families for whom unpredictable closures and transitions to virtual learning come at a cost, may present difficult decisions between employment and child care responsibilities, and could result in major financial impacts on their household.

July 2021 data show that two percent of centers (393) were closed due to COVID–19, 14 percent of centers were operating in a virtual/remote service delivery model (2,861), and 45 percent of centers were operating in a hybrid service delivery model (9,181). Only 35 percent of centers (7,240) were operating fully in person.

September 2021 center operating status data shows 73 percent (14,917) of the centers are open for in-person only services, 14 percent (2,892) are operating in a hybrid model of in-person and virtual/remote services, and 4 percent (835) are open for virtual/remote only. Two percent (324) of centers remain entirely closed due to COVID–19 and the remaining 7 percent of centers are unreported, closed for the season, or closed due to a natural disaster. The increase in the number of programs delivering services in-person only is consistent with the expectations OHS outlined in May 2021 that programs move toward fully in-person services as soon as possible by January 2022, factoring in local health conditions.[66] This data also show that while closures declined, at least 20 percent of programs are closed, operating a virtual/remote service delivery model only, or in a hybrid model. Programs need to be able to resume fully in-person services to meet the needs of children and families, for all the reasons discussed in this section of the IFC.

A vaccination requirement and consistent and correct mask use are critical in mitigating SARS-CoV–2 transmission and keeping Head Start programs open. Program closures impede Head Start families from participating in the workforce, impose financial hardship on low wage workers who may not have paid time off to care for children who are in quarantine, create instability for children and families who depend on the Head Start program, and delay a full economic recovery for the nation.

HHS Secretary's Extension of Public Health Emergency

On January 31, 2020, Health and Human Services Secretary Alex M. Azar II determined that a public health emergency (PHE) exists retroactive to January 27, 2020,[67] under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID–19. This declaration has been extended every 90 days since then and most recently on October 18, 2021. The current PHE declaration extends until mid-January 2022.

C. Waiver of Proposed Rulemaking

In accordance with the Administrative Procedure Act (APA), 5 U.S.C. 553, ACF ordinarily publishes a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule before the provisions of the rule take effect. Specifically, 5 U.S.C. 553(b) generally requires the agency to publish a notice of the proposed rule in the **Federal Register** that includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. Section 553(c) further requires the agency to give interested parties the opportunity to participate in the rulemaking through public comment before the provisions of the rule take effect. Section 553(b)(B) authorizes the agency to waive these procedures, however, if the agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

The 2021 outbreaks associated with the SARS-Cov-2 Delta variant have shown that current levels of COVID–19 vaccination coverage up until now have been inadequate to protect Head Start staff, children, and families. The data showing the effectiveness of vaccination indicate to us that we cannot delay taking this action in order to protect the health and safety of children and families, and the staff providing care.

We recognize that newly reported COVID–19 cases, hospitalizations, and deaths have begun to trend downward at a national level; nonetheless, they remain substantially elevated relative to numbers seen in May and June 2021, just before the Delta variant became the predominant strain circulating in the U.S.[68] And while cases are trending downward in some states, there are emerging indications of potential increases in others—particularly northern states where the weather has begun to turn colder.[69] The United States experienced a large COVID–19 wave in the winter of 2020. As of November 18, 2021, over 30 percent of people aged 12 years and older in the United States remain not fully vaccinated—and this situation could pose a threat to the country's progress on the COVID–19 pandemic, potentially incurring a fifth wave of COVID–19 cases.[70]

[63] Office of Head Start Information Memorandum. Mandated Reporting of Child Abuse and Neglect ACF–IM–HS–15–04. September 18, 2015. Available at: *https://eclkc.ohs.acf.hhs.gov/policy/im/acf-im-hs-1504#:~:text=Staff%20who%20need%20help%20identifying,800%2D422%2D4453).&text=All%20Head%20Start%20programs%20must,of%20child%20abuse%20and%20neglect.*

[64] Child Trends. "How Early Head Start Prevents Child Maltreatment." November 1, 2018. Available at: *https://www.childtrends.org/publications/how-early-head-start-prevents-child-maltreatment.*

[65] United States Department of Health and Human Services. "Head Start Program Information Report." Available at: *https://eclkc.ohs.acf.hhs.gov/data-ongoing-monitoring/article/program-information-report-pir.*

[66] Office of Head Start. Office of Head Start (OHS) Expectations for Head Start Programs in Program Year (PY) 2021–2022. May 20, 2021. Available at: *https://eclkc.ohs.acf.hhs.gov/policy/pi/acf-pi-hs-21-04.*

[67] United States Department of Health and Human Services. "Public Health Emergency." January 31, 2020. Available at: *https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVDI-15Oct21.aspx.*

[68] *https://covid.cdc.gov/covid-data-tracker/#datatracker-home.*

[69] *https://www.cdc.gov/flu/professionals/acip/background-epidemiology.htm.*

[70] Centers for Disease Control. "COVID Data Tracker." November 18, 2021. Available at: *https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.*

The efficacy of COVID–19 vaccinations has been demonstrated.[71] An ASPE report published on October 5, 2021, found that COVID–19 vaccines are a key component in controlling the COVID–19 pandemic. Clinical data show vaccines are highly effective in preventing COVID–19 cases and severe outcomes including hospitalization and death. Vaccines continue to be effective in preventing COVID–19 associated with the now-dominant Delta variant.[72] [73]

In addition to preventing morbidity and mortality associated with COVID–19, the vaccines also appear to be effective against asymptomatic SARS–CoV–2 infection. A recent study of health care workers in 8 states found that, from December 14, 2020, through August 14, 2021, full vaccination with COVID–19 vaccines was 80 percent effective in preventing RT–PCR–confirmed SARS–CoV–2 infection among frontline workers.[74] Emerging evidence also suggests that vaccinated people who become infected with Delta have the potential to be less infectious than infected unvaccinated people, thus decreasing transmission risk.[75] For example, in a study of breakthrough infections among health care workers in the Netherlands, SARS-CoV–2 infectious virus shedding was lower among vaccinated individuals with breakthrough infections than among unvaccinated individuals with primary infections.[76]

As noted earlier in this section, a combination of factors, including but not limited to failure to achieve sufficiently high levels of vaccination based on voluntary efforts and patchwork requirements, potential harm to children from unvaccinated staff, continuing strain on the health care system, and known efficacy and safety of available vaccines, have persuaded us that a vaccine requirement for Head Start staff, certain contractors, and volunteers is an essential component of the nation's COVID–19 response. Further, it would endanger the health and safety of staff, children and families, and be contrary to the public interest to delay imposing the vaccine mandate. Therefore, we believe it would be impracticable and contrary to the public interest for us to undertake normal notice and comment procedures and to thereby delay the effective date of this IFC. We find good cause to waive notice of proposed rulemaking under the APA, 5 U.S.C. 552(d), 553(b)(B). For those same reasons, as authorized by subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (the Congressional Review Act or CRA), 5 U.S.C. 808(2), we find it is impracticable and contrary to the public interest not to waive the delay in effective date of this IFC under the CRA. Therefore, we find there is good cause to waive the CRA's delay in effective date pursuant to 5 U.S.C. 808(2).

IV. Background

Since its inception in 1965, Head Start has been a leader in supporting children from low-income families in reaching kindergarten healthy and ready to thrive in school and life. The program was founded on research showing that health and wellbeing are pre-requisites to maximum learning and improved short- and long-term outcomes. In fact, OHS identifies health as the foundation of school readiness.

The Head Start Program Performance Standards require children to be up to date on immunizations and their state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule (45 CFR 1302.42(b)(1)(i)). When children are behind on immunizations or other care, Head Start programs are required to ensure they get on a schedule to catch up. Additionally, education, family service, nutrition, and health staff help children learn healthy habits, monitor each child's growth and development, and help parents access needed health care. It is vitally important that enrolled pregnant women and children from birth to five years can access in-person services. When children are able to participate in their regular, in-person program options, they form a secure attachment to and relationship with their Head Start teachers. A large body of research demonstrates that a secure attachment with caregivers is a critical foundation for children to learn and explore their environment.[77] Furthermore, education staff who see children in person are better able to monitor their progress and individualize teaching and learning. The youngest children, children from birth to five years, need physical interaction with materials and in-person support for optimal learning. Screen based learning is much less effective and necessarily limited in the number of hours. Finally, as many parents return to work, they need the assurance that their children are in a safe and high-quality learning environment.

It is equally important that the Head Start program itself is safe for all children, families, and staff. For this reason, the Head Start Program Performance Standards specify that the program must ensure staff do not pose a significant risk of communicable disease (45 CFR 1302.93(a)). Ensuring that children and families can benefit from program services as safely as possible is OHS' highest priority. While this is always important, the COVID–19 pandemic highlights the need to ensure staff are as protected as possible so that children under age 5 years, who cannot yet be vaccinated, are also protected. Fully vaccinated staff are at much lower risk of infection and therefore, pose lower transmission risk to the young unvaccinated children in their care.[78] Young children who get the virus can also spread it to others in their homes and communities. Ensuring Head Start staff are fully vaccinated significantly reduces the possibility of the program playing an unwitting part in community spread of SARS-CoV–2.

On October 29, 2021 the U.S. Food and Drug Administration authorized the Pfizer-BioNTech mRNA vaccine for COVID–19 for use in children ages five to 11. On November 2, 2021, CDC adopted the CDC Advisory Committee on Immunization Practices' (ACIP) recommendation that children 5 to 11 years old be vaccinated for COVID–19 with the Pfizer-BioNTech pediatric vaccine. While Head Start does serve some children who are currently eligible for a vaccine, children five and older only represented 1.11 percent of children enrolled in Head Start programs during the 2020–2021 program year (Office of Head Start—Program Information Report [PIR] Enrollment Statistics Report—2021—National Level). As of November 11, 2021, there is no pediatric COVID–19 vaccine available for children younger than age five years in the United States.

To the extent a court may enjoin any part of the rule, the Department intends

[71] *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html.*

[72] *https://www.nejm.org/doi/full/10.1056/nejmoa2108891.*

[73] *https://www.mayoclinic.org/coronavirus-covid-19/covid-variant-vaccine.*

[74] *https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e4.htm?s_cid=mm7034e4_w.*

[75] *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html#ref43.*

[76] *https://www.medrxiv.org/content/10.1101/2021.08.20.21262158v1.full.pdf.*

[77] Bergin, C., & Bergin, D. (2009). Attachment in the classroom. *Educational Psychology Review, 21*(2), 141–170.; Rees, C. (2007). Childhood attachment. *British Journal of General Practice, 57*(544), 920–922.; Sierra, P. G. (2012). Attachment and preschool teacher: An opportunity to develop a secure base. *International Journal of Early Childhood Special Education (INT–JECSE), 4*(1), 1–16.

[78] Centers for Disease Control and Prevention. "COVID–19 Guidance for Operating Early Care and Education/Child Care Programs." November 10, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/child-care-guidance.html.*

that other provisions or parts of provisions should remain in effect. Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

V. Provisions of the Interim Final Rule

This interim final rule (IFR) adds new provisions to the Head Start Program Performance Standards to require: (1) Effective immediately, and with exceptions discussed below, universal masking for all individuals two years of age and older regardless of program option, (2) all Head Start staff, certain contractors, and volunteers in classrooms or working directly with children to be fully vaccinated for COVID–19, with exemptions discussed below, and (3) for those granted an exemption to the requirement specified in (2) at least weekly testing for current SARS–CoV–2 infection.

The definition of *staff* in § 1305.2 is "paid adults who have responsibilities related to children and their families who are enrolled in programs." Consistent with that definition, "all staff" as noted in this IFC, refers to all staff who work with enrolled Head Start children and families in any capacity regardless of funding source. The term "Head Start" is inclusive of Head Start, Early Head Start, and Early Head Start-Child Care Partnerships.

Consistent with CDC's guidance, in general, fully vaccinated[79] means

(i) a person's status 2 weeks after completing primary vaccination with a COVID–19 vaccine with, if applicable, at least the minimum recommended interval between doses in accordance with the approval, authorization, or listing that is:

(A) Approved or authorized for emergency use by the Food and Drug Administration (FDA);

(B) Listed for emergency use by the World Health Organization (WHO); or

(C) Administered as part of a clinical trial at a U.S. site, if the recipient is documented to have primary vaccination with the "active" (not placebo) COVID–19 vaccine candidate, for which vaccine efficacy has been independently confirmed (*e.g.*, by a data and safety monitoring board) or if the clinical trial participant at U.S. sites had received a COVID–19 vaccine that is neither approved nor authorized for use by FDA but is listed for emergency use by WHO; or

(ii) A person's status 2 weeks after receiving the second dose of any combination of two doses of a COVID–19 vaccine that is approved or authorized by the FDA, or listed as a two-dose series by WHO (*i.e.*, a heterologous primary series of such vaccines, receiving doses of different COVID–19 vaccines as part of one primary series). The second dose of the series must not be received earlier than 17 days (21 days with a 4-day grace period) after the first dose.

A. Masking Requirement

This IFC adds a new provision to part1302, subpart D—Health Program Services in § 1302.47, Safety practices. Section 1302.47(b)(5), Safety practices, specifies the appropriate practices all staff and consultants follow to keep children safe during all activities. This IFC creates a new paragraph (vi) that requires universal masking for all individuals aged 2 years and older when there are two or more individuals in a vehicle owned, leased, or arranged by the Head Start program; indoors in a setting when Head Start services are provided; and for those not fully vaccinated, outdoors in crowded settings or during activities that involve sustained close contact with other people. The Office of Head Start notes that being outdoors with children inherently includes sustained close contact for the purposes of caring for and supervising children.

There are different types of masks. Head Start staff should choose a mask that is comfortable to wear and fits snugly. It must cover one's mouth, nose, and chin. It can fasten around the ears or the back of the head, as long as it stays in place when one talks and moves. Masks with vents or exhalation valves are not allowed because they allow unfiltered breath to escape the mask. For more information on masks, programs can consult Your Guide to Masks | CDC.

Purchasing masks needed for staff to fulfill their duties and responsibilities and for children is considered an allowable use of Head Start program funds, as well as the COVID–19 response funds and the American Rescue Plan funds.[80] Programs should have masks available to provide to children when they do not have their own mask.

This requirement is effective immediately upon publication of this IFC. Exceptions are noted for when individuals are eating or drinking; for children when they are napping; for the narrow subset of persons who cannot wear a mask, or cannot safely wear a mask, because of a disability as defined by the Americans with Disabilities Act (ADA), consistent with CDC guidance on disability exemptions;[81] and for children with special health care needs, for whom programs should work together with parents and follow the advice of the child's health care provider for the best type of face covering. It should be noted that like all new skills, children will need to be taught the proper way to put a mask on and keep a mask on. While children are adaptable, they are still in the early stages of development and may need reminders and reinforcements to comply with this new practice. It is imperative that Head Start staff abide by the Standards of Conduct outlined in 1302.90 Personnel Policies in the Head Start Program Performance Standards namely that staff, consultants, contractors, and volunteers implement positive strategies to support children's well-being and do not use harsh disciplinary practices that could endanger the health or safety of children.

B. Vaccination Requirement

This IFC adds four new provisions to part 1302, subpart I—Human Resources Management in § 1302.93, Staff health and wellness, and § 1302.94, Volunteers. Section 1302.93(a), Staff health and wellness, states that "the program must ensure staff do not, because of communicable diseases, pose a significant risk to the health or safety of others in the program that cannot be eliminated or reduced by reasonable accommodation, in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act." This IFC adds a new paragraph (a)(1) to § 1302.93 requiring all staff, and those contractors whose activities involve contact with or providing direct services to children and families, to be fully vaccinated for COVID–19, except for those (i) for whom a vaccine is medically contraindicated, (ii) for whom

[79] Centers for Disease Control and Prevention. "When You've Been Fully Vaccinated." October 15, 2021. *https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html.*

[80] Office of Head Start. "FY 2021 American Rescue Plan Funding Increase for Head Start Programs." May 4, 2021. Available at: *https://eclkc.ohs.acf.hhs.gov/policy/pi/acf-pi-hs-21-03.*

[81] Centers for Disease Control. Order: Wearing of face masks while on conveyances and at transportation hubs. January 21, 2021. Available at: Order: Wearing of face masks while on conveyances and at transportation hubs | Quarantine | CDC.

medical necessity requires a delay in vaccination,[82] or (iii) who are legally entitled to an accommodation with regard to the COVID–19 vaccination requirement based on an applicable Federal law. It also adds a new paragraph (a)(2) indicating that those who are granted an exemption outlined in (a)(1)(i) through (iii) must undergo testing at least weekly for current SARS COV–2 infection.

The additions made to § 1302.94, Volunteers, mirrors that of § 1302.93, Staff health and wellness. This IFC also adds a new paragraph (a)(1) to § 1302.94, Volunteers, that requires all volunteers who are in classrooms or working directly with children other than their own must be fully vaccinated for COVID–19, except for those (i) for whom a vaccine is medically contraindicated, (ii) for whom medical necessity requires a delay in vaccination,[83] or (iii) who are legally entitled to an accommodation with regard to the COVID–19 vaccination requirement based on an applicable Federal law. It also adds a new paragraph (a)(2) indicating that those who are granted an exemption outlined in paragraphs (a)(1)(i) through (iii) must undergo testing at least weekly for current SARS-CoV–2 infection. The costs associated with regular testing for those granted an exemption are an allowable use of Head Start funds so long as it is included in a program's policies and procedures. While paying for the costs associated with regular testing is allowable use of Head Start funds, it is not a requirement. Programs should consider whether they can sustain continued funding for testing if/when the COVID–19 funds are exhausted. Finally, we have also revised § 1302.94 to remove the word "regular" from paragraph (a). We believe it is important for all volunteers to adhere to these requirements not just those who regularly volunteer in the program.

Programs may use SARS–CoV–2 testing for all staff, regardless of vaccination status, as an additional mitigation strategy with the COVID–19 vaccines, and those granted exemptions are required to undergo testing, but testing alone is not an alternative to the COVID–19 vaccination requirement specified in § 1302.93 and § 1302.94.

[82] As defined by CDC's informational document, Summary Document for Interim Clinical Considerations for Use of COVID–19 Vaccines Currently Authorized in the United States (CDC, September 29, 2021).

[83] As defined by CDC's informational document, Summary Document for Interim Clinical Considerations for Use of COVID–19 Vaccines Currently Authorized in the United States (CDC, September 29, 2021).

This is a key difference between this IFC and the COVID–19 Vaccination and Testing; Emergency Temporary Standard, published, by the Occupational Safety and Health Administration (OSHA) on November 5, 2021, which requires employers with 100 or more employees to develop, implement, and enforce a mandatory COVID–19 vaccination policy, unless they adopt a policy requiring employees to choose to either be vaccinated or undergo regular SARS–Cov–2 testing and wear a face covering. Whereas OSHA allows employers to offer an option for testing and face coverings, this IFC does not permit a testing and face coverings option for individuals without an approved vaccine exemption. The rationale for the difference is that ACF is acting under statutory and regulatory standards that are different from OSHA's. In general, the Head Start Act requires standards for a safe environment for staff, children, and other participants.

Documentation of Vaccination Status

The Head Start Act at section 647 (42 U.S.C. 9842) has a provision on record-keeping, which allows the Secretary to require certain records be kept and to support OHS in conducting its oversight of programs through monitoring. Pursuant to the statutory recordkeeping requirement in section 647 of the Head Start Act (42 U.S.C. 9842) and in order to ensure programs are complying with the vaccination requirements of this IFC, we are requiring that they track and securely document the vaccination status of each staff member, including those for whom there is a temporary delay in vaccination, such as recent receipt of monoclonal antibodies or convalescent plasma. Vaccination exemption requests and outcomes must also be documented, discussed further in section II.A.5. of this IFC. This documentation will be an ongoing process as new staff are onboarded.

While program staff may not have personal medical records on file with their employer, all staff COVID–19 vaccines must be appropriately documented by the provider or supplier. All medical records, including vaccine documentation, must be kept confidential and stored separately from an employer's personnel files, pursuant to the ADA and the Rehabilitation Act.

Examples of acceptable forms of proof of vaccination include:

- CDC COVID–19 vaccination record card (or a legible photo of the card),
- Documentation of vaccination from a health care provider or electronic health record, or
- State immunization information system record.

If vaccinated outside of the United States, a reasonable equivalent of any of the previous examples would suffice.

Programs have the flexibility to use the appropriate tracking tools of their choice. For those who would like to use it, CDC provides a staff vaccination tracking tool that is available on the NHSN website (*https://www.cdc.gov/nhsn/hps/weekly-covid-vac/index.html*). This is a generic Excel-based tool available for free to anyone, not just NHSN participants, that facilities can use to track COVID–19 vaccinations for staff members.

Exemption Process

Under Federal law, including the Americans with Disabilities Act (ADA) and Title VII of the Civil Rights Act of 1964, staff, contractors, and volunteers who cannot be vaccinated because of a disability under the ADA, medical condition, or sincerely held religious beliefs, practice, or observance may in some circumstances be granted an exemption, as discussed in II.B of this IFC. Head Start staff included in this IFC must be able to request an exemption from these COVID–19 vaccination requirements. Additionally, programs following CDC guidelines and the new requirements in this IFC may also be required to provide reasonable accommodations, to the extent required by federal law, for employees who request and receive exemption from vaccination because of a disability, medical condition, or sincerely held religious belief, practice, or observance.

In support of the new requirements in §§ 1302.93 and 1302.94, it is the responsibility of Head Start programs to establish a process for reviewing and reaching determinations regarding exemption requests (e.g., disability, medical conditions, sincerely held religious beliefs, practices, or observances). Programs must have a process for collecting and evaluating such requests, including the tracking and secure documentation of information provided by those staff who have requested exemption, the program's decision on the request, and any accommodations that are provided. Requests for exemptions based on an applicable federal law must be documented and evaluated in accordance with applicable Federal law and each program's policies and procedures. As is relevant here, this IFC preempts the applicability of any state or local law providing for exemptions to the extent such law provides broader exemptions than provided for by federal law and are inconsistent with this IFC.

For staff members, contractors, and volunteers who request a medical exemption from vaccination, all documentation confirming recognized clinical contraindications to COVID–19 vaccines or medical need for delay, and which supports the request, must be signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable state and local laws. Such documentation must contain all information specifying which of the authorized or approved COVID–19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications or the recognized clinical reasons necessitating delay in vaccination; and a statement by the authenticating practitioner recommending that the staff member be exempted from the program's COVID–19 vaccination requirements based on the recognized clinical contraindications or allowed to delay vaccination.

For more information, Head Start programs can refer to a resource produced by the Equal Employment Opportunity Commission (EEOC), which is responsible for enforcing federal laws that prohibit employment-related discrimination based on a person's race, color, religion, sex (including pregnancy, gender identity, and sexual orientation), national origin, age (40 or older), disability, or genetic information. The EEOC resource, What You Should Know About COVID–19 and the ADA, the Rehabilitation Act, and Other EEO Laws, available at What You Should Know About COVID–19 and the ADA, the Rehabilitation Act, and Other EEO Laws | U.S. Equal Employment Opportunity Commission (*eeoc.gov*), should be helpful in navigating employees' requests for accommodations (EEOC, October 25, 2021).

In granting such exemptions or accommodations, programs must ensure that they minimize the risk of transmission of SARS–CoV–2 to at-risk individuals, in keeping with their obligation to protect the health and safety of staff, children and families. To that end, it is a reasonable alternative that staff, contractors, and volunteers granted an accommodation be required to undergo testing at least weekly for current SARS–CoV–2 infection. Because unvaccinated employees are at higher risk of SARS–CoV–2 infection, and SARS–CoV–2 transmission among individuals without symptoms is a significant driver of COVID–19, ACF has determined it is necessary to prevent the pre-symptomatic and asymptomatic transmission of SARS–CoV–2 from unvaccinated staff, contractors and volunteers, through a requirement for a weekly screening test.[84] Although more regular screening testing (*e.g.*, twice weekly) may identify even more cases, ACF has decided to require a minimum testing of only on a weekly basis, which is in line with CDC recommendations.

In support of this requirement, programs should develop and implement a written SARS–CoV–2 testing protocol for those staff, contractors, and volunteers granted vaccine exemptions. Programs should consult with their Health Services Advisory Committee (HSAC) and local public health officials, along with recommendations from their agency's legal counsel and Human Resources department in the development of a SARS–CoV–2 testing protocol. Programs are encouraged to review guidance from CDC and FDA about selecting SARS–CoV–2 tests and developing related protocols. The costs of regular testing for those granted an exemption are an allowable use of Head Start funds so long as it is included in a program's policies and procedures. While using Head Start funds is allowable, it is not a requirement. It is at the program's discretion to decide if they will pay for the cost of testing, considering such factors as the number of approved exemptions, whether they can sustain continued funding for testing if/when the COVID–19 funds are exhausted, any incentives associated with allowing the use of funds for testing, and whether employees can cover the expenses of testing.

D. Implementation Dates

Due to the urgent nature of the vaccination requirements established in this IFC, we have not issued a proposed rule, as discussed in section C of this IFC. While some IFCs, or provisions within IFCs, are effective immediately upon publication, such as the mask requirement, we understand that instantaneous compliance, or compliance within days, with the vaccine requirement is not possible. Vaccination requires time, especially vaccines delivered in a series. Programs' updates to their policies and procedures also take time to develop. However, in order to provide protection to staff, children, and families, we believe it is necessary to begin staff vaccinations as quickly as reasonably possible. Therefore, we have set the January 31, 2022 as the compliance date for staff to be vaccinated. Although an individual is not considered fully vaccinated until 14 days (2 weeks) after the final dose, staff, certain contractors and volunteers who have received the final dose of a primary vaccination series by January 31, 2022 are considered to have met the vaccination requirement, even if they have not yet completed the 14-day waiting period. This timing flexibility applies only to the initial implementation of this IFC and has no bearing on ongoing compliance.

The rationale for a different timeline for compliance with the vaccine requirement in this rule relative to the CMS or the OSHA rule is because this timeline in this rule is coordinated with OHS's expectation, communicated through guidance in May 2021, for programs' return to full in-person services. Beginning January 2022, Head Start programs are expected to resume fully in-person services after a period of increased flexibility with virtual and remote services during the pandemic. At this time, OHS will reinstate pre-pandemic practices for tracking and monitoring enrollment as part of the Full Enrollment Initiative. This means that during the first week of February, OHS will evaluate reported enrollment on the last day of January for purposes of the under-enrollment process. Requiring that staff receive their second dose in a two-dose vaccine series, or a single dose in a one-dose vaccine series, by January 31 is consistent with this return to fully in-person services.

VI. Regulatory Process Matters

Treasury and General Government Appropriations Act of 1999

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires federal agencies to determine whether a policy or regulation may negatively affect family well-being. If the agency determines a policy or regulation negatively affects family well-being, then the agency must prepare an impact assessment addressing seven criteria specified in the law. ACF believes it is not necessary to prepare a family policymaking assessment, *see* Public Law 105–277, because the action it takes in this interim final rule will not have any impact on the autonomy or integrity of the family as an institution. However, ACF invites public comment on whether the actions set forth in this interim final rule would have a negative effect on family well-being.

[84] OSHA. "COVID–19 Vaccination and Testing; Emergency Temporary Standard." November 5, 2021. Available at: *https://www.federalregister.gov/documents/2021/11/05/2021-23643/covid-19-vaccination-and-testing-emergency-temporary-standard.*

Federalism Assessment Executive Order 13132

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule would preempt some State laws that prohibit employers from requiring their employees to be vaccinated for COVID–19. Consistent with the Executive Order, we find that State and local laws that forbid employers in the State or locality from imposing vaccine requirements on employees directly conflict with this exercise of our statutory authority to protect the health and safety of Head Start participants and their families and ensure the continuation of services by requiring vaccinations for staff, certain contractors, and volunteers and universal masking. As is relevant here, this IFC preempts the applicability of any State or local law providing for exemptions to the extent such law provides broader grounds for exemptions than provided for by Federal law and are inconsistent with this IFC. In these cases, consistent with the Supremacy Clause of the Constitution, the agency intends that this rule preempts State and local laws to the extent the State and local laws conflict with this rule. The agency has considered other alternatives (for example, relying entirely on measures such as voluntary vaccination, source control alone, and physical distancing) and has concluded that the mandate established by this rule is the minimum regulatory action necessary to achieve the objectives of the statute. Given the transmission rates of the existing strains of coronavirus and their disproportionate impacts on low-income communities served by Head Start programs, we believe that vaccination of almost all staff, certain contractors, and volunteers is necessary to promote and protect program participants and ensure program continuity. The agency has examined case studies from other employers and concludes that vaccine mandates are vastly more effective than other measures at achieving ideal vaccination rates and the resulting protections. Given the emergency situation with respect to the Delta variant detailed more fully above, time did not permit usual consultation procedures. We are, however, inviting comments on the substance as well as legal issues presented by this rule.

Congressional Review Act

Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act or CRA) allows Congress to review "major" rules issued by federal agencies before the rules take effect, *see* 5 U.S.C. 801(a). The CRA defines a major rule as one that has resulted, or is likely to result, in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, or innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets, see 5 U.S.C. 804(2). The Office of Information and Regulatory Affairs in the Office of Management and Budget has determined that this action is a major rule because it will have an annual effect on the economy of $100 million or more.

Paperwork Reduction Act of 1995

The Paperwork Reduction Act (PRA) of 1995, 44 U.S.C. 3501 *et seq.*, minimizes government-imposed burden on the public. In keeping with the notion that government information is a valuable asset, it also is intended to improve the practical utility, quality, and clarity of information collected, maintained, and disclosed.

The PRA requires that agencies obtain OMB approval, which includes issuing an OMB number and expiration date, before requesting most types of information from the public. Regulations at 5 CFR part 1320 implemented the provisions of the PRA and § 1320.3 of this part defines a "collection of information," "information," and "burden." PRA defines "information" as any statement or estimate of fact or opinion, regardless of form or format, whether numerical, graphic, or narrative form, and whether oral or maintained on paper, electronic, or other media (5 CFR 1320.3(h)). This includes requests for information to be sent to the government, such as forms, written reports and surveys, recordkeeping requirements, and third-party or public disclosures (5 CFR 1320.3(c)). "Burden" means the total time, effort, or financial resources expended by persons to collect, maintain, or disclose information.

This IFC establishes new recordkeeping requirements under the PRA. Head Start grant recipients are required as part of this IFC to maintain records on staff vaccination rates. Additionally, Head Start programs are required to develop their own written SARS–CoV–2 testing protocol for current infection for individuals granted vaccine exemptions. To promote flexibility for local programs, there is no standardized instrument associated with the new recordkeeping requirement. As required under the PRA, ACF will submit a request for approval of these recordkeeping requirements. We will initially request approval through an emergency clearance process, allowing for 6 months of approval under the PRA. We will follow the initial approval with a full request, including two public comment periods, to extend approval of the recordkeeping requirement. A separate notice inviting comments on these new recordkeeping requirements will be published in the **Federal Register**.

In addition to these new recordkeeping requirements, Head Start grant recipients are expected to update their program policies and procedures to ensure costs associated with regular testing for those granted an exemption are an allowable use of Head Start funds. The recordkeeping activity of maintaining program policies and procedures including the associated burden with updating them on an annual basis is already approved under an existing OMB information collection (Control Number 0970–0148). The separate **Federal Register** notice will also invite comments on this existing recordkeeping requirement.

VII. Economic Analysis of Impacts

Introduction

We have examined the impacts of this interim final rule under Executive Order 12866, Executive Order 13563, and the Regulatory Flexibility Act (5 U.S.C. 601–612). Executive Orders 12866 and 13563 direct us to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). We believe, and OIRA determined, that this interim final rule is an economically significant regulatory action as defined by Executive Order 12866. Thus, this rule has been reviewed by the Office of Information and Regulatory Affairs.

The Regulatory Flexibility Act requires us to analyze regulatory options that would minimize any significant impact of a rule on small entities. Because the impacts to small entities

attributable to the interim final rule are limited in nature, we certify that the interim final rule will not have a significant economic impact on a substantial number of small entities. These impacts are discussed in detail in the Final Small Entity Analysis.

Summary of Costs and Benefits

This interim final rule establishes vaccine, record keeping, and mask requirements to mitigate the spread of SARS–CoV–2 in Head Start programs. We have evaluated the likely impacts of the interim final rule in comparison to a baseline scenario of no new regulation that incorporates projections of COVID–19 vaccine coverage, cases, deaths, and hospital admissions. We anticipate that the requirement that all Head Start staff get fully vaccinated for COVID–19 will induce a substantial portion of unvaccinated staff to get fully vaccinated. We also estimate that the regulation will induce a similar number, but smaller share, of unvaccinated Head Start volunteers to get fully vaccinated in response to the interim final rule. Some Head Start volunteers are likely also covered by other regulatory actions, which complicates attributing changes in vaccine coverage to any particular regulatory action. We discuss this in greater detail in the Baseline Section and Benefits Section.

The increase in vaccine coverage attributable to the interim final rule will result in substantial health benefits from reductions in COVID–19 mortality and morbidity. We monetize these impacts using a Value per Statistical Life (VSL) for fatal cases, and estimates of the Value per Statistical Case (VSC) that vary by case severity for non-fatal cases. We also predict that reductions in COVID–19 cases among Head Start staff will result in lower absenteeism, including fewer missed days of work for staff infected with SARS–CoV–2 or recovering from COVID–19 and unvaccinated staff quarantining after a close contact tested positive for SARS–CoV–2. We monetize these impacts using a value of time that accounts for time savings for parents and other caregivers for children enrolled at Head Start centers. We estimate a range of total monetized benefits between $200 million and $296 million under a 7% discount rate, and a range between $196 million and $288 million under a 3% discount rate. These monetized benefits cover a time period between the publication date of the interim final rule and March 1, 2022, when our underlying COVID–19 projections end. For our main analysis, we assume that the requirements will be effective for this time horizon, but also consider a scenario in which the requirements are lifted at an earlier date, such as by the COVID–19 Public Health Emergency expiring. The choice of discount rate impacts the benefit estimates through the VSC, which is based on estimates of the Value per Quality-Adjusted Life Year that vary by discount rate.

In addition to the impacts that we monetize in this analysis, we anticipate that the increase in vaccine coverage attributable to the interim final rule will result in indirect health benefits from reduced transmission of SARS–COV–2, the virus that causes COVID–19. These impacts include reductions in secondary infections from Head Start staff and volunteers to other staff and volunteers, children, and families. We anticipate that the masking requirement will also reduce transmission SARS–COV–2 from individuals covered by the requirement. This impact includes a reduction in transmission from children to Head Start teachers, staff, and other children. We also discuss a mechanism and valuation approach for monetizing benefits from Head Start centers reopening. We discuss these impacts in greater detail in the Benefits Section, and note that they are embedded in a quantitative approach in the Net Benefits section.

We have identified several costs that are attributable to the interim final rule. We monetize the costs of vaccination, which incorporates a value of time for staff and volunteers, and the cost of doses and administration; the costs of the masking requirement; the costs of testing unvaccinated staff and volunteers; and the costs of recordkeeping associated with the interim final rule. We also consider a scenario where a share of unvaccinated Head Start staff quit rather than get fully vaccinated. Under this scenario, these costs would include training replacement staff, and the costs to parents and other caregivers for children enrolled at Head Start center resulting from staff vacancies. We estimate a range of costs between $16 million and $83 million, which cover a time period between the publication of the interim final rule and March 1, 2022, which is consistent with the time horizon adopted for our benefits estimates. These cost estimates do not vary with the discount rate. We also discuss potential additional costs of masking and testing associated with Head Start centers reopening as a result of the interim final rule.

Table 1 presents a summary of the monetized impacts attributable to the interim final rule. All dollar estimates are presented in millions of 2020 dollars. We request comments on these benefit and cost estimates.

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Table 1. Summary of Benefits, Costs and Distributional Effects of Interim final rule

Category		Primary Estimate	Low Estimate	High Estimate	Units			Notes
					Year Dollars	Discount Rate	Period Covered	
Benefits	Annualized Monetized $millions/year	$247,964,991	$200,294,622	$295,635,335	2020	7%	3 months	
		$242,185,591	$195,986,161	$288,384,996	2020	3%	3 months	
	Annualized Quantified					7%		
						3%		
	Qualitative							
Costs	Annualized Monetized $millions/year	$49,456,037	$15,612,352	$83,299,721	2020	7%	3 months	
		$49,456,037	$15,612,352	$83,299,721	2020	3%	3 months	
	Annualized Quantified					7%		
						3%		
	Qualitative							
Transfers	Federal Annualized Monetized $millions/year					7%		
						3%		
	From/To	From:			To:			
	Other Annualized Monetized $millions/year					7%		
						3%		
	From/To	From:			To:			
Effects	State, Local or Tribal Government: Small Business: Wages: Growth:							

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We have developed a comprehensive Economic Analysis of Impacts that assesses the impacts of the final rule. The full analysis of economic impacts is available in the docket for this final rule (Ref. [insert reference number]). We request comments on this analysis.

VIII. Alternatives Considered

In making the decision to require vaccination and mask use, ACF considered whether to require other mitigation strategies or combinations of mitigation strategies. The CDC's recently issued guidance on November 10, 2021 reiterates the importance of using multiple prevention strategies in ECE programs.[85] In addition to vaccinations and masks, other strategies noted in this IFC include staying home if sick; handwashing; improving ventilation; screening and diagnostic testing; cleaning and disinfecting; keeping physical distance; and cohorting.

There are two primary reasons that ACF decided to mandate vaccination and mask use. First, Head Start programs have a broad set of program performance standards that already include requirements for infection control, exclusion policies, cleaning, sanitizing and disinfecting. The requirement for staying home when sick is part of § 1302.47(b)(4)(i)(A); hand hygiene (handwashing) is included at § 1302.47(b)(6)(i); cleaning, sanitizing, and disinfecting is at § 1302.47(b)(2)(i); and physical distancing is part of § 1302.47(b)(4)(i)(A), which OHS sees as a strategy for a program's infection control practices). In addition, § 1302.47(b)(1)(iii) states that facilities need to be "free from pollutants, hazards and toxins that are accessible to children and could endanger children's safety," though it is difficult be overly prescriptive about ventilation given the range of facilities and spaces used by center-based and family child care programs.

Second, as discussed in this IFC, being fully vaccinated for COVID–19 and using a mask are two of the most effective mitigation strategies available to reduce transmission of COVID–19.[86] With this in mind, ACF determined a federal requirement is necessary. While some agencies and localities have implemented vaccine and masking requirements, many have not. Additionally, vaccine uptake among Head Start staff has not been as robust as hoped for and has been insufficient to protect the health and safety of children and families receiving Head Start services. Combined, these factors leave certain children and families with fewer mitigation strategies in place to protect them than others. It is ACF's responsibility to make sure the environment is as safe as possible for Head Start programs uniformly across all 1,600 grant recipients.

Additionally, although less effective and efficient than vaccination, the CDC has recognized regularly testing unvaccinated individuals for SARS–CoV–2 as a useful tool for identifying asymptomatic and/or pre-symptomatic infected individuals so that they can be isolated,[87] which informed the decision to include in this IFC a testing policy for those granted an exemption. It is also consistent with the CDC's guidance on November 11, 2021, which added screening testing information to its prevention strategies. This guidance notes that in ECE programs, screening testing can help promptly identify and isolate cases, quarantine those who may have been exposed to SARS–CoV–2 and are not fully vaccinated, and identify clusters to reduce the risk to in-person education. The inclusion of a requirement for masking, vaccination and testing, for those staff, contractors and volunteers granted an exemption, ensures the Head Start Program Performance Standards reflect the current science with respect to reducing the spread of SARS–CoV–2 and reducing COVID–19.

ACF also deliberated on the question of whether to require Head Start programs to cover the cost of testing for those granted an exemption or to shift those costs to staff. Head Start staff are not high wage earners, and we recognize it could create hardship for staff granted an exemption to absorb the cost of weekly testing. That said, if programs have many staff who are approved for exemptions, it could be difficult for the program to bear the cost of weekly testing, particularly when their COVID–19 response funds are exhausted. Given these various factors, ACF determined that it is important to make it allowable to use funds at this time, including both COVID–19 response funds and ongoing program funds, for the purpose of testing but allow programs the discretion to make the decision based on budgetary factors, the number of staff approved for an exemption, incentives or other factors. We invite comment on this decision.

ACF also considered whether to tie the universal masking requirement and the testing requirement to SARS–CoV–2 transmission rates. For example, the requirement could make masking voluntary once community transmission drops below a certain level, consistent with CDC guidance. There are more than 1600 Head Start grant recipients, many of which serve multiple communities, cross state lines or serve an entire state. Transmission rates could be significantly different across service areas. For example, one grant recipient in Michigan covers 21 different counties. It would be burdensome for this program to issue separate guidance across its service area to account for changing transmission levels across those counties. Another grant recipient, Alabama Department of Resources, has a partnership that covers the entire state of Alabama. Again, it would be burdensome for this grant recipient to change its mask guidance for different centers through the state as transmission rates change. ACF values CDC guidance that localities should monitor community transmission in making decisions and has relied on the importance of local health conditions in issuing guidance to Head Start programs. However, in the case of mask use, ACF is prioritizing a clear and transparent policy that is easy for grantees to follow across their service areas. Additionally, children benefit from routine and predictability. ACF determined that the best course of action was not to provide an end date on the universal masking and testing requirement. ACF invites comment on this decision to leave an undetermined end date or whether we should set a finite end date, such as 6 months from the effective date of the rule.

[85] Centers for Disease Control and Prevention. "COVID–19 Guidance for Operating Early Care and Education/Child Care Programs." November 10, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/child-care-guidance.html.*

[86] Centers for Disease Control and Prevention. "Science Brief: COVID–19 Vaccines and Vaccination." September 15, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html#:~:text=Evidence%20suggests%20the%20US%20COVID,interrupting%20chains%20of%20transmission.*

[87] Centers for Disease Control and Prevention. "Overview of Testing for SARS–CoV–2 (COVID–19). October 22, 2021. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html.*

Appendix to Section VII of Supplementary Information: Economic Analysis of Impacts

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Vaccine and Mask Requirements To Mitigate the Spread of COVID–19 in Head Start Programs

Final Regulatory Impact Analysis; Final Regulatory Flexibility Analysis; Unfunded Mandates Reform Act Analysis; Office of Head Start, Administration for Children and Families, Department of Health and Human Services

Prepared by

Office of Science and Data Policy

Office of the Assistant Secretary for Planning and Evaluation

Office of the Secretary

Department of Health and Human Services

I. Introduction and Summary

A. Introduction

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		$242,185,591	$195,986,161	$288,384,996	2020	3%	3 months	
	Annualized Quantified					7%		
						3%		
	Qualitative							
Costs	Annualized Monetized $millions/year	$49,456,037	$15,612,352	$83,299,721	2020	7%	3 months	
		$49,456,037	$15,612,352	$83,299,721	2020	3%	3 months	
	Annualized Quantified					7%		
						3%		
	Qualitative							
Transfers	Federal Annualized Monetized $millions/year					7%		
						3%		
	From/To	From:			To:			
	Other Annualized Monetized $millions/year					7%		
						3%		
	From/To	From:			To:			
Effects	State, Local or Tribal Government: Small Business: Wages: Growth:							

II. Economic Analysis of Impacts

A. Background

Since its inception in 1965, Head Start has been a leader in helping children from low-income families reach kindergarten healthy and ready to thrive in school and life. The program was founded on research showing that health and wellbeing are pre-requisites to maximum learning and improved short- and long-term outcomes. In fact, the Office of Head Start identifies health as the foundation of school readiness.

The Head Start Program Performance Standards require children to be up to date on immunizations and their state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule. When children are behind on immunizations or other care, Head Start programs are required to ensure they get on a schedule to catch up. Additionally, education, family service, nutrition, and health staff help children learn healthy habits, monitor each child's growth and development, and help parents access needed health care. It is vitally important that enrolled pregnant women and children from birth to 5 can access in person services, especially after so many children spent a year or more away from in-person Head Start services.

It is equally important that the Head Start program itself is safe for all children, families, and staff. For this reason, the Head Start Program Performance Standards specify that the program must ensure staff do not pose a significant risk of communicable disease that cannot be eliminated or reduced by reasonable accommodation, in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Ensuring that children and families can benefit from program services as safely as possible is the Office of Head Start's highest priority.

COVID–19 has resulted in substantial reductions in in-person Head Start services available to children and their families. As described in greater detail in the Baseline Section, a majority of Head Start centers have moved from fully in-person services to a virtual/remote or a hybrid operating status, while other centers remain closed as a result of a COVID–19 case or outbreak in a program. Without the vaccination and masking requirements of this regulatory action, there is a higher likelihood of transmission of SARS–COV–2 at in-person Head Start settings, which would result in more people at greater risk for COVID–19-related morbidity and mortality, including children returning home and exposing family members. This interim final rule is needed to address the health risks from COVID–19 and to increase the likelihood that Head Start centers are able to reopen or return to in-person services safely.

C. Purpose of the Rule

This regulatory action requires COVID–19 vaccination among all staff employed in Head Start programs, as well as for volunteers that interact with children. The interim final rule also requires mask wearing for all adults and children aged 2 years and older in certain in-person Head Start settings. This regulation also requires recordkeeping of vaccination status for both volunteers and staff. This regulation is necessary to ensure healthy, safe conditions for in-person early care and education services to children and their families enrolled in Head Start programs nationwide. Being fully vaccinated against COVID–19, combined with wearing a mask, are the safest and most effective ways for Head Start programs to mitigate the spread of COVID–19 among the children and families they serve, as well as among staff and volunteers. This action will help more early childhood centers safely remain open and provide needed services to Head Start children and families.

D. Baseline Conditions

This section describes the baseline scenario of no new regulatory action from which the incremental changes to these outcomes from the policy options considered are measured. The scope of this economic analysis is limited to the impacts that are attributable to this regulatory action, which covers more than 20,000 Head Start Centers. The requirements of this interim final rule will cover about 273,000 staff, and a share of the 1 million Head Start volunteers who interact with children in certain in-person Head Start settings. It will also impact a share

of the 864,000 children in certain in-person Head Start settings.

On September 9, 2021, President Biden announced the "Path Out of the Pandemic" COVID–19 Action Plan,[88] which announced the development of a Head Start vaccination requirement, and other elements of a national strategy to combat COVID–19. In our primary analysis, we exclude impacts attributable to other elements of this comprehensive national strategy. For example, the COVID–19 Action Plan announced the development of the Emergency Temporary Standard (ETS) recently issued by the Department of Labor's Occupational Safety and Health Administration (OSHA). Among other provisions, the OSHA ETS requires employers with 100 or more employees to develop, implement, and enforce a mandatory COVID–19 vaccination policy, unless they adopt a policy requiring employees to choose to either be vaccinated or undergo regular COVID–19 testing and wear a face covering. Centers for Medicare & Medicaid Services (CMS) also recently issued an interim final rule with comment period that requires COVID–19 vaccinations for workers in most health care settings that receive Medicare or Medicaid reimbursement.[89] The OSHA action covers over 80 million workers, while the CMS action will apply to approximately 76,000 providers and cover more than 17 million health care workers across the country. Additionally, through Executive Orders 14042, "Ensuring Adequate COVID Safety Protocols for Federal Contractors" [90] and 14043, "Requiring Coronavirus Disease 2019 Vaccination for Federal Employees," [91] and other actions, all federal executive branch employees, including the military, and all federal contractors will be required to be fully vaccinated. In total, the vaccination requirements associated with the Action Plan apply to about 100 million Americans.

These actions (if implemented, despite ongoing litigation) would likely have significant impacts on the measured outcomes described in this baseline scenario. For example, a recent White House report [92] discusses existing vaccination requirements and summarizes several potential impacts of widespread adoption of such requirements, such as those envisioned in the Action Plan:

"[V]accination requirements have repeatedly been shown to increase vaccination rates among workers by 20 to 25 percentage points, and in some cases by significantly more. More than three out of four (75.5%) working-aged adult Americans are currently in the labor force, so increasing the share of workers who are fully vaccinated by 20 to 25 percentage points could vaccinate an additional 30 to 38 million working-age Americans, cutting the total share of unvaccinated Americans roughly in half. This could have a major effect on case rates, hospitalization rates, and death rates—preventing future waves of the virus from having as significant an effect as occurred during the spread of the Delta variant. At an individual level, unvaccinated people are more than five times as likely to get a symptomatic case of COVID–19 and more than 10 times as likely to be hospitalized or to die from COVID–19."

There are challenges in extrapolating from private-sector or smaller jurisdiction mandates to broader action by the federal government, especially in regards to the effectiveness of the mandates; however, the estimates contained in the White House Report are broadly consistent with DOL's estimate "that approximately 75.3 million (89.4 percent) of covered employees will be vaccinated when the ETS is in full effect." [93] We exclude these potential spill-over impacts in characterizing our baseline, adopting a regulatory scenario that does not account for other elements of the COVID–19 Action Plan.

The scope of the COVID–19 vaccine requirement is limited to staff at Head Start programs and volunteers that interact with children at Head Start programs. To characterize the baseline scenario, we present forecasts that are specific to the 273,000 staff employed or contracted by Head Start programs,[94] and discuss volunteers separately. We provide quantitative projections of COVID–19 vaccine coverage, and for each of the COVID–19 outcomes described above. Our forecasts are based on COVID–19 Projections maintained by the Institute for Health Metrics and Evaluation (IHME).[95] IHME summarizes its projections in a Data Release Information Sheet:

"IHME has developed projections for total and daily deaths, daily infections and testing, hospital resource use, and social distancing due to COVID–19 for a number of countries. Forecasts at the subnational level are included for select countries. The projections for total deaths, daily deaths, and daily infections and testing each include a reference scenario: Current projection, which assumes social distancing mandates are re-imposed for 6 weeks whenever daily deaths reach 8 per million (0.8 per 100k). They also include two additional scenarios: Mandates easing, which reflects continued easing of social distancing mandates, and mandates are not re-imposed; and Universal Masks, which reflects 95% mask usage in public in every location. Hospital resource use forecasts are based on the Current projection scenario. Social distancing forecasts are based on the Mandates easing scenario. These projections are produced with a model that incorporates data on observed COVID–19 deaths, hospitalizations, and cases, information about social distancing and other protective measures, mobility, and other factors. They include uncertainty intervals and are being updated daily with new data. These forecasts were developed in order to provide hospitals, policy makers, and the public with crucial information about how expected need aligns with existing resources, so that cities and countries can best prepare."

We adopt the IHME reference scenario as the source of our baseline forecasts. Since the IHME estimates are "produced with a model that incorporates data on observed COVID–19 deaths, hospitalizations, and cases, information about social distancing and other protective measures, mobility, and other factors," this significantly narrows the wide range of analytic choices that would otherwise be necessary to characterize the baseline scenario. Since the IHME projections cover the entire United States population, we adjust these projections to align with data specific to Head Start. We discuss the specific adjustments in the following narrative.

Vaccine Coverage

A recent study measured "COVID–19 Vaccine Uptake Among U.S. Child Care Providers," with 21,663 respondents, including 1,456 individuals providing services through Head Start or Early Head Start. Among Head Start survey respondents, 73.0% reported receiving a COVID–19 vaccine. We interpret this to mean that respondents had received at least one dose. This interpretation is consistent with the study's comparison to the general adult population. The authors note that "[t]he survey was active between May 26, 2021 and June 23, 2021," and compare the overall findings to vaccine uptake for the U.S. general adult population of 65%.[96] Since Head Start staff are more likely to be vaccinated than the general adult population, our baseline forecast will reflect this difference. Specifically, we extend this point-in-time estimate to the vaccine coverage forecasts by adopting an assumption that Head Start staff are about 12% more likely to be vaccinated than the general adult population,[97] and that this relationship will persist under the time horizon of the baseline scenario of this analysis. As a sample calculation, if the general adult population vaccine coverage rate increases to 67.1%, we would infer a corresponding increase in the Head Start vaccine coverage rate to 74.6%.[98]

The Center for Disease Control and Prevention (CDC) maintains a COVID Data

[88] *https://www.whitehouse.gov/covidplan/.*

[89] *https://www.federalregister.gov/documents/2021/11/05/2021-23831/medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-vaccination.*

[90] *https://www.federalregister.gov/documents/2021/09/14/2021-19924/ensuring-adequate-covid-safety-protocols-for-federal-contractors.*

[91] *https://www.federalregister.gov/documents/2021/09/14/2021-19927/requiring-coronavirus-disease-2019-vaccination-for-federal-employees.*

[92] *https://www.whitehouse.gov/wp-content/uploads/2021/10/Vaccination-Requirements-Report.pdf.*

[93] *https://www.govinfo.gov/content/pkg/FR-2021-11-05/pdf/2021-23643.pdf.*

[94] *https://eclkc.ohs.acf.hhs.gov/about-us/article/head-start-program-facts-fiscal-year-2019.*

[95] Institute for Health Metrics and Evaluation (IHME). COVID–19 Mortality, Infection, Testing, Hospital Resource Use, and Social Distancing Projections. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), University of Washington, 2020. *http://www.healthdata.org/covid/data-downloads.* Accessed on November 10, 2022.

[96] Patel KM, Malik AA, Lee A, et al. (2021). "COVID–19 vaccine uptake among US child care providers." *Pediatrics:* doi: 10.1542/peds.2021–053813.

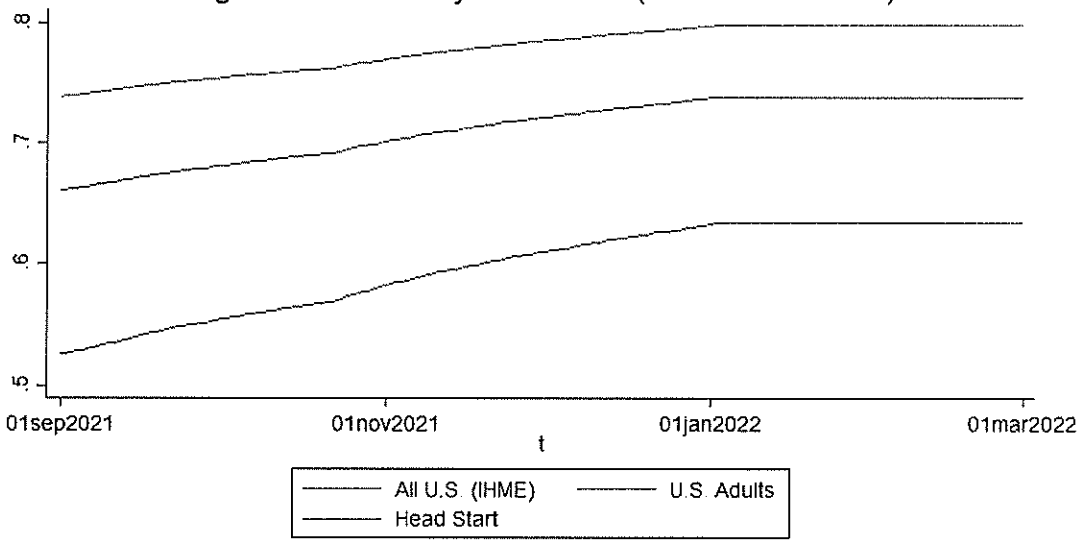
[97] 0.73/0.65 ≈ 1.12. We perform calculations in the model based on the share of individuals who are unvaccinated. The comparable calculation is 1 − [(1 − 0.73)/(1 − 0.65)] ≈ 0.23, which indicates that Head Start staff are about 23% less likely to be unvaccinated than the general adult population.

[98] 1 − [(1 − 0.671) * (1 − 0.23)] ≈ 0.75.

Tracker on its website, which includes a summary of COVID–19 vaccinations in the United States. On November 10, 2021, CDC reports that 58.5% of the total U.S. population are fully vaccinated, and reports 70.3% for a subset of the population that are 18 years of age or older (hereafter, "adults").[99] The IHME COVID–19 projections are reported at a population level, and do not contain separate projections that are limited to the adult population. Therefore, generating a baseline forecast of vaccine coverage among Head Start staff from the IHME projections first requires an intermediate step of estimating vaccine coverage for the adult population. We follow the same approach for this adjustment as we discussed to translate adult vaccine coverage estimates to Head Start staff vaccine coverage estimates. Specifically, we calculate a point-in-time relationship using November 10, 2021 CDC data, and assume that this relationship will persist over the time horizon of the analysis. We assume that adults are about 20.1% more likely to be vaccinated than the total population.[100] Combining the adjustments, a population vaccine coverage rate on November 10, 2021 for the total U.S. population of 58.5% would correspond to a 77.1% Head Start vaccine coverage rate.[101]

We assume that vaccination coverage will continue to increase over time and incorporate this into our baseline. For example, the IHME projections indicate U.S. vaccine coverage of 60.0% on November 18, 2021. This estimate increases to 63.4% on March 1, 2022, the last date covered in the most recent IHME projections available at the time of the analysis. We assume that vaccine coverage for Head Start will follow a similar trajectory, after accounting for the adjustments described above, and incorporate this into our baseline. Figure 1 presents forecasts of vaccine uptake under the baseline scenario. These forecasts include the unadjusted IHME projections for the total population, our adjustments to project adult vaccination coverage, and adult vaccination coverage specific to Head Start staff. For Head Start, we anticipate the vaccine coverage rate will increase from 77.9% on November 18, 2021 to 79.8% on March 1, 2022 under the baseline scenario of no further regulatory action.

Figure 1: Share Fully Vaccinated (Baseline Scenario)



COVID–19 Cases, Deaths, and Hospitalizations Among U.S. Adults

The IHME projections include estimates for infections, new hospital admissions, and deaths at a population level. Several adjustments are necessary to convert these population-level estimates to estimates appropriate for the Head Start staff population characteristics. Specifically, we adjust for the age distribution and vaccine coverage rates of Head Start staff. We discuss these adjustments in the narrative contained in the next two sections.

We generate projections of daily cases by multiplying IHME's projections of daily infections with its daily estimates of the infection detection ratio.[102] Over the period covering November 19, 2021 to March 1, 2022, the estimated infection detection ratio varies between 0.4693 and 0.4993, suggesting that, on any particular day, measured COVID–19 cases likely represent between 47% and 49% of the total COVID–19 infections. We assume that this measure is consistent with the CDC's case definition.[103] We acknowledge the importance of these additional infections that are not confirmed cases but focus on the metric of confirmed COVID–19 cases, which is more comparable with other sources of data used in this analysis.

We make several initial adjustments of the IHME projections, which cover the entire U.S. population, to generate forecasts that are limited to the adult population. Using CDC COVID–19 line-level case surveillance data that cover July 1–September 30, 2021, we estimate that 21% of COVID–19 cases were individuals aged <18 years.[104] We adjust the total population case projections by this percentage to capture only adult cases. We follow the same procedure for mortality: CDC case surveillance data indicate that 0.1% of COVID–19 deaths were individuals aged <18 years. We adjust the total population death projections by this percentage to capture only adult deaths.[105] We follow the same procedure for hospitalizations: CDC COVID–NET data on laboratory-confirmed COVID–19 associated hospitalizations indicate that 1.9% of COVID–19 hospitalizations were

[99] *https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.*

[100] 0.703/0.585 ≈ 1.20. Calculated in the model as 1 − [(1 − 0.703)/(1 − 0.585)] ≈ 0.284, with the interpretation is adults are about 28.4% less likely to be unvaccinated than the total population.

[101] 1 − {(1 − .585) * (1 − 0.284) * (1 − 0.23)] ≈ 0.771.

[102] *http://www.healthdata.org/special-analysis/covid-19-estimating-historical-infections-time-series.*

[103] *https://ndc.services.cdc.gov/case-definitions/coronavirus-disease-2019-2021/.*

[104] Calculation based on CDC COVID–19 Line level case surveillance data, HHS Protect. 1,414,206/6,589,127 ≈ 0.21. This share is somewhat higher in recent months than in earlier periods. For all documented COVID–19 cases through September 30, 2021, the share is 14% (4,461,790/31,537,748 ≈ 0.14). Accessed October 8, 2021.

[105] Calculation based on data extracted from *https://covid.cdc.gov/covid-data-tracker/#demographics.* 637/567,704 ≈ 0.001. Accessed October 3, 2021.

individuals aged <18 years.[106] We adjust the total population hospital admission projections by this percentage to capture only adult hospital admissions. We note that the hospitalization data provide more limited coverage than data on cases and deaths. This adjustment assumes that the distribution of hospitalizations by age nationally are similar to the underlying data. We believe this assumption is more justified, in the context of this analysis, than not performing an adjustment.

Figure 2 presents the IHME projections of daily infections, cases, and our estimates of adult cases. Figure 3 presents the IHME projection of daily excess deaths and reported deaths. This analysis focuses on the projections of reported deaths, which are more comparable with other data sources used in this analysis. Figure 4 presents the IHME projections of daily new hospital admissions and adjusted estimates for adult cases.

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Figure 2: Daily Infections and Cases (100,000s) (Baseline Scenario)

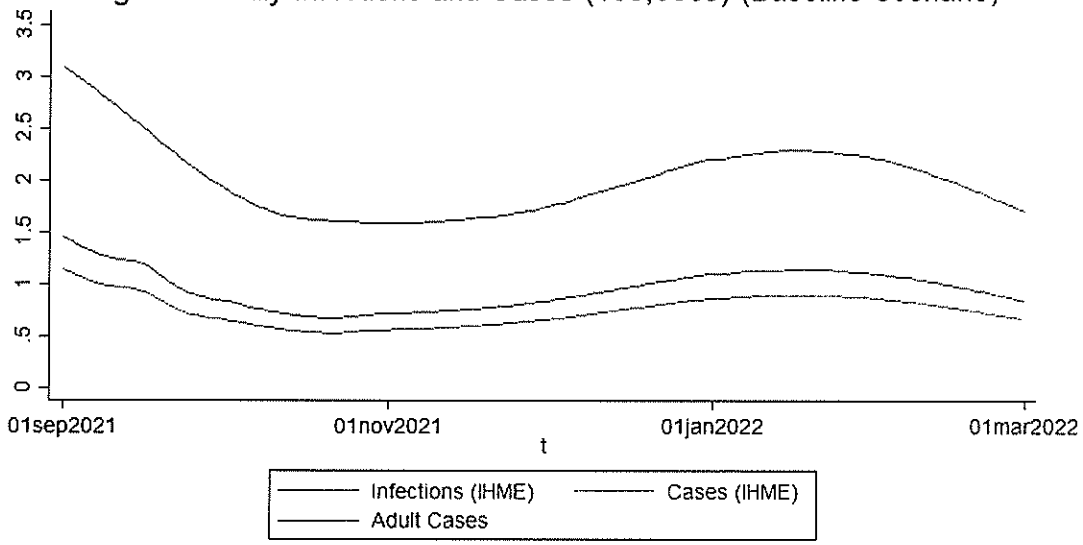
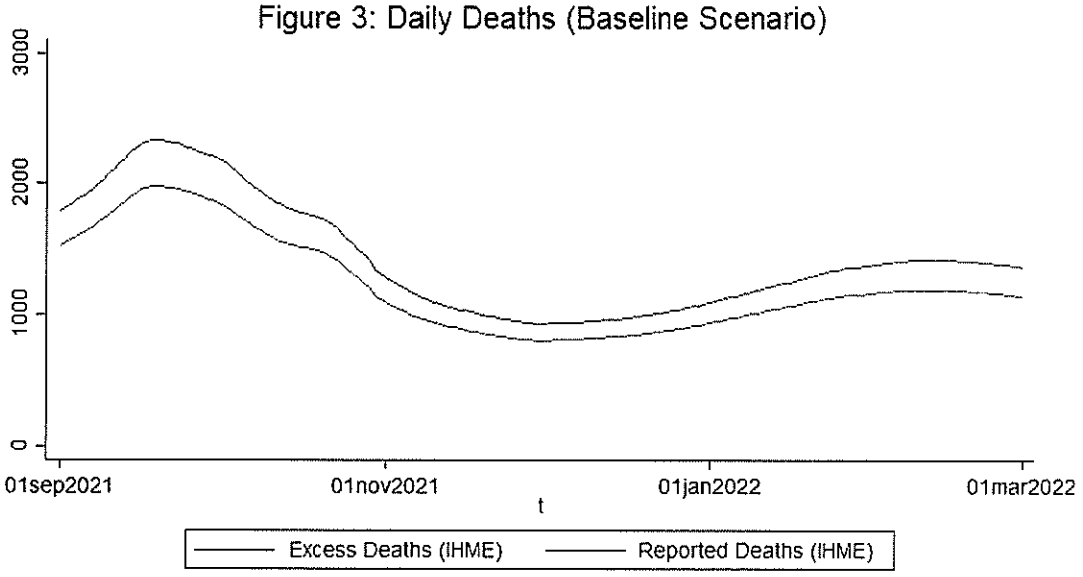
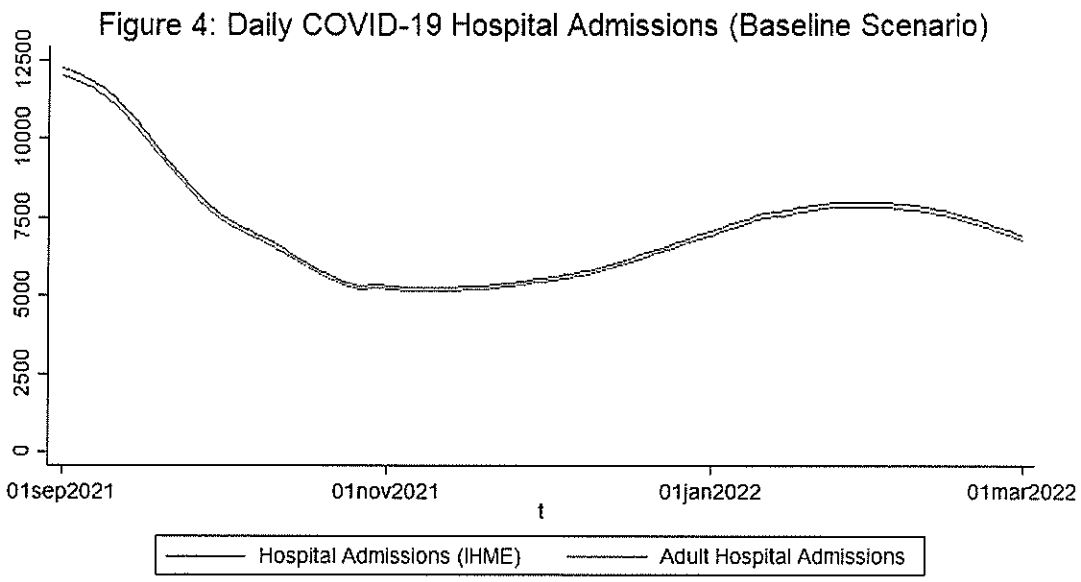


Figure 3: Daily Deaths (Baseline Scenario)



[106] Calculation based on COVID–19-Associated Hospitalization Surveillance Network, Centers for Disease Control and Prevention. *https://gis.cdc.gov/grasp/covidnet/COVID19_5.html*. 4,228/220,539 = 0.019. Accessed on October 3, 2021.



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COVID–19 Cases, Deaths, and Hospital Admissions Among Head Start Staff

Head Start staff differ from the general U.S. adult population level in several ways. First, the size of the population is much smaller. Using the IHME total population estimate of about 328 million, and a Census estimate of the population share of adults of about 78%,[107] we compute a total of 255 million adults. The 273,000 Head Start staff represent about 0.1% of total adults. As an initial adjustment, we adjust the baseline scenario estimates of daily cases, deaths, and hospital admissions downward to reflect the population under the scope of the interim final rule.

If Head Start staff had a COVID–19 risk profile that matched the adult population, no further adjustments would be necessary; however, as described above, a higher share of Head Start staff are fully vaccinated than the adult population as a whole, and we expect this trend to continue through the time horizon of the baseline scenario of this analysis. To properly account for the risk reductions to Head Start staff attributable to higher vaccination rates, we perform an adjustment based on published estimates of the incidence rate ratios (IRRs) that compare outcomes for unvaccinated and vaccinated persons at a population level, which provide a measure of vaccine effectiveness.[108]

This CDC study reports averaged weekly, age-standardized IRRs for cases, hospitalizations, and deaths, among persons who were not fully vaccinated (simplified later by describing these as "unvaccinated") compared with those among fully vaccinated persons. The IRRs suggest that vaccinated individuals experienced a significantly reduced risk of infection, hospitalization, and death, including during a period when Delta became the most common variant. For the June 20–July 17, 2021 period, the point estimates of the average weekly IRRs for all ages were 4.6 for cases, 10.4 for hospitalizations, and 11.3 for deaths. For individuals between ages 18 and 49 years, these estimates are 4.5 for cases, 15.2 for hospitalizations, and 17.2 for deaths. For individuals between ages 50 and 64 years, these estimates are 4.9 for cases, 10.9 for hospitalizations, and 17.9 for deaths. For individuals aged ≥65 years, these estimates are 4.6 for cases, 7.6 for hospitalizations, and 9.6 for deaths.

The IRR of 4.6 for cases means that vaccination offers strong protection against COVID–19 and that fully vaccinated people had about a five-fold reduction in risk of infection compared with people not fully vaccinated. These IRR estimates cover adults and are standardized to match the U.S. adult population. They are calculated by dividing average weekly incidence on a per capita basis among unvaccinated individuals by the incidence among fully vaccinated individuals. For example, the study calculates the IRR for cases by dividing 89.1 cases per 100,000 unvaccinated individuals by 19.4 cases per 100,000 vaccinated individuals.[109]

For comparison, the CDC study underlying these estimates also reports higher measurements of the IRR during an earlier time period, covering April 4–June 19, 2021. Specifically, the comparable IRR estimates were 11.1 for cases, 13.3 for hospitalizations, and 16.6 for deaths. The study does not disentangle the changes in the IRR measurements across these time periods that are attributable to the highly transmissible Delta variant or other factors, such as the potential decline in vaccine effectiveness as the time since vaccination increases. Although the IRRs are unlikely to remain constant over time, the estimates corresponding to the June 20–July 17, 2021 period represent the best available estimates of the IRR for the time horizon of this analysis.

We also generate IRR estimates specific to the Head Start teacher population. These estimates reflect differences in the age distribution of Head Start teachers rather than observational data on COVID–19 cases, since ACF does not collect this information. To generate these estimates, we pair the age-specific IRR estimates with the corresponding age range for Head Start teachers. ACF data indicates that 10.4% of Head Start teachers are ages 18–29 years; ages 30–39 years, 29.6%; ages 40–49 years, 26.7%; ages 50–59 years, 21.7%; and ages >60 years, 11.6%.[110] For the purposes of this analysis, we assume that half of Head Start teachers 60 years and older are ages 60–64 years, and half are ages >65 years. Table 2 presents the central estimates of the age-standardized IRRs for cases, hospitalizations and deaths for the adult population, as reported in the CDC study, and IRRs for the same outcomes, but standardized for the age profile of Head Start teachers. We later apply these estimates, which reflect the Head Start teacher age

[107] *https://www.census.gov/popclock/data_tables.php?component=pyramid.*

[108] Scobie HM, Johnson AG, Suthar AB, et al. (2021). "Monitoring Incidence of COVID–19 Cases, Hospitalizations, and Deaths, by Vaccination Status—13 U.S. Jurisdictions, April 4–July 17, 2021." Morbidity and Mortality Weekly Report 2021;70:12841290. DOI: *http://dx.doi.org/10.15585/mmwr.mm7037e1.*

[109] 89.1/19.4 ≈ 4.6.

[110] Doran, Elizabeth, Natalie Reid, Sara Bernstein, Tutrang Nguyen, Myley Dang, Ann Li, Ashley Kopack Klein, Sharika Rakibullah, Myah Scott, Judy Cannon, Jeff Harrington, Addison Larson, Louisa Tarullo, and Lizabeth Malone (2021). A Portrait of Head Start Classrooms and Programs in Spring 2020: FACES 2019 Descriptive Data Tables and Study Design, OPRE Report #2021–215, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Pending Publication.

profile, for a broader population of Head Start staff.

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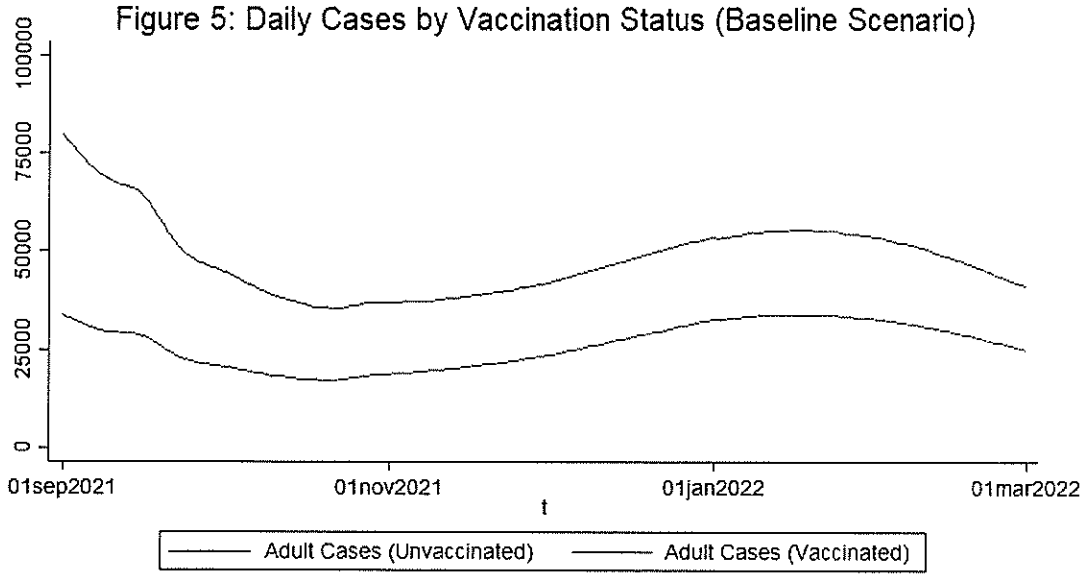
Table 2. Incidence Rate Ratios for Adults and Head Start Teachers

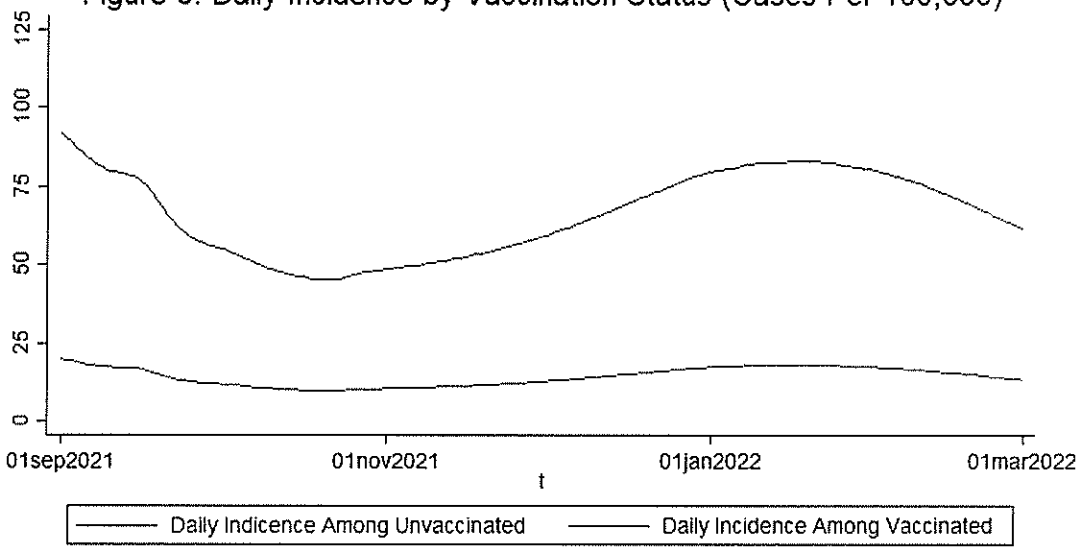
Age Range (years)	Share of Teachers	Case IRR	Hospitalization IRR	Death IRR
18-29	10.4%	4.5	15.2	17.2
30-39	29.6%	4.5	15.2	17.2
40-49	26.7%	4.5	15.2	17.2
50-59	21.7%	4.9	10.9	17.9
60-64	5.8%	4.9	10.9	17.9
65+	5.8%	4.6	7.6	9.6
Adults		4.6	10.4	11.3
Head Start		4.6	13.6	17.0

By adopting the adult age-standardized IRR estimates, we are able to disaggregate COVID–19 cases among unvaccinated individuals from cases among vaccinated individuals. Figure 5 presents these estimates for the adult population.

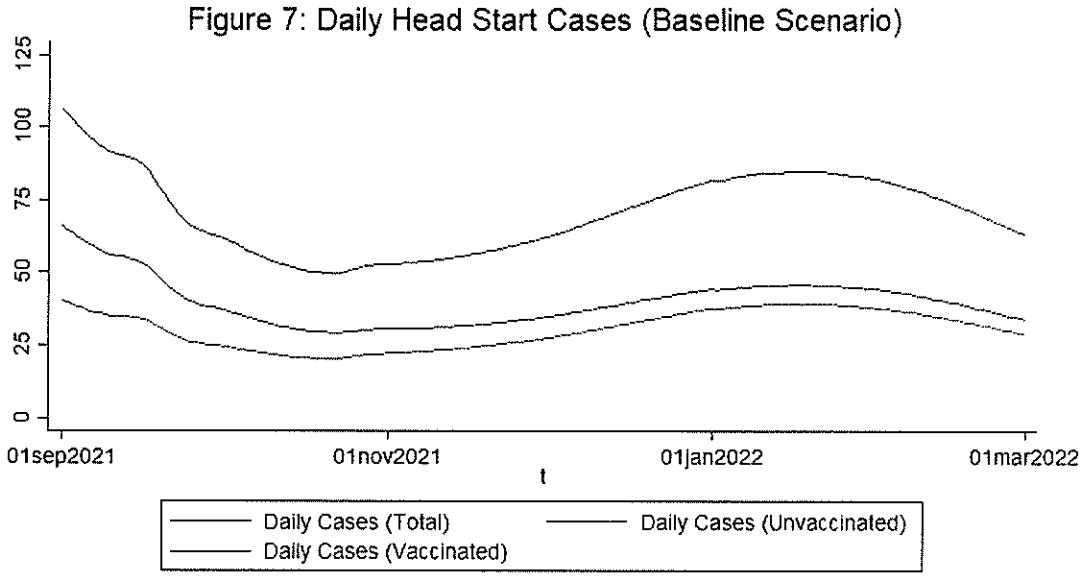


We combine estimates of the daily adult cases among unvaccinated individuals and daily estimates of the unvaccinated adult population to generate daily incidence rates among unvaccinated individuals on a per capita basis. We perform similar calculations to generate daily incidence rates among vaccinated individuals on a per capita basis. Figure 6 reports the daily incidence over time and by vaccination status. These estimates are reported as cases per 100,000 individuals. For the last week in our projections, covering February 23, 2022 to March 1, 2022, the weekly incidence rate for unvaccinated adults is about 446 cases per 100,000, while the weekly incidence rate for vaccinated adults is about 97 cases per 100,000, which is consistent with a 4.6 IRR. This time period corresponds to an adult vaccination rate of 73.8%, for a total adult weekly incidence rate of about 188 cases per 100,000, and a total weekly adult case count of 480,523.

Figure 6: Daily Incidence by Vaccination Status (Cases Per 100,000)



To generate estimates of cases among Head Start staff, we combine the estimates of vaccine uptake from Figure 1, estimates of the daily incidence by vaccination status, applying the IRR measure specific to Head Start staff, with outcomes scaled by the number of Head Start staff. This approach assumes, for the purpose of developing quantitative projections, that daily exposure to COVID–19 among Head Start staff is largely driven by interactions with the public as a whole and that Head Start staff face similar exposure to these risks as other adults. If Head Start staff face greater exposure to these risks than the adult population, such as through routine contact with children who are generally not eligible for a COVID–19 vaccination, this will cause our baseline estimates of cases, hospitalizations, and deaths among Head Start staff to be downward biased. This would similarly result in our estimates of the health benefits from increases in vaccine coverage to be downward biased. We project that Head Start staff will experience lower per-capita case counts than the general adult population due to higher rates of vaccination, and a higher IRR rate consistent with the age profile of Head Start staff compared to all adults. Figure 7 presents daily Head Start cases. For the last week in our projections, covering February 23, 2022 to March 1, 2022, we estimate about 457 total cases, with 246 cases from unvaccinated, and 211 cases from vaccinated Head Start staff. These cases translate to a baseline Head Start weekly incidence rate of about 167 cases per 100,000.



We generate estimates of the Head Start deaths and hospital admissions using the same approach as we describe for cases. We adopt IRR estimates specific to the Head Start staff population of 17.0 for deaths and an IRR of 13.6 for hospitalizations. These IRRs indicate that the COVID–19 vaccines provide even stronger protection against COVID–19 associated hospitalization and death than against infections. We perform adjustments to the adult incidence rates that are intended to control for deaths and hospital admissions that are concentrated in older age groups than we observe among Head Start staff.

Using CDC surveillance data through October 3, 2021, we observe that, among the 567,704 COVID–19 deaths in the United States for which age data are available, 319,311 deaths are among individuals ≥75 years. While the Head Start workforce includes a number of older individuals, very few are ≥75 years. Head Start data indicate that 11.6% of teachers are age 60 years or older, compared to the general population share of 22.7%. We anticipate that almost all of the Head Start teachers age 60 years or older are between age 60 and 74 years, and assume this is also true for the broader Head Start staff population. Therefore, we adjust the adult death incidence rate to exclude deaths among individuals ≥75 years. This adjustment reduces the baseline forecast for Head Start deaths downwards by about 56%.[111] Older individuals are also hospitalized at higher rates than younger peers, but this difference is less pronounced than for deaths. Among laboratory-confirmed COVID–19-associated hospitalizations for which age data are available, about 43% are individuals ≥65 years,[112] an age subgroup representing about 16.5% of the total population. Since only 5.8% of Head Start staff are individuals ≥65 years, we reduce the total population baseline forecasts for hospitalizations by about two thirds[113] of 43%, or about 28%,[114] since we expect a significant share of these hospitalizations to be among individuals older than most Head Start staff.

Figure 8 reports daily Head Start deaths attributable to COVID–19 under the baseline scenario. For the entire period of the baseline scenario, we anticipate fewer than one COVID–19 related death per day among Head Start staff. For the last week in our projections, covering February 23, 2022 to March 1, 2022, we estimate 2.9 weekly deaths out of the total Head Start staff population of 273,000. To provide additional context, this is a weekly incidence rate of 1.06 deaths per 100,000 individuals. The comparable adult weekly incidence rate is about 3.18 deaths per 100,000 individuals. Figure 9 reports daily Head Start hospital admissions. For the last week in our projections, we estimate 29 hospital admissions for a weekly incidence rate of 10.8 per 100,000.

[111] 319,311/(567,704 − 637) ≈ 0.56.
[112] 92,960/(220,539 − 4,228) ≈ 0.43.
[113] 0.058/0.165 ≈ 0.35. 1 − 0.35 = 0.65.
[114] 0.43 * 0.65 ≈ 0.28.

Figure 8: Daily Head Start Deaths (Baseline Scenario)

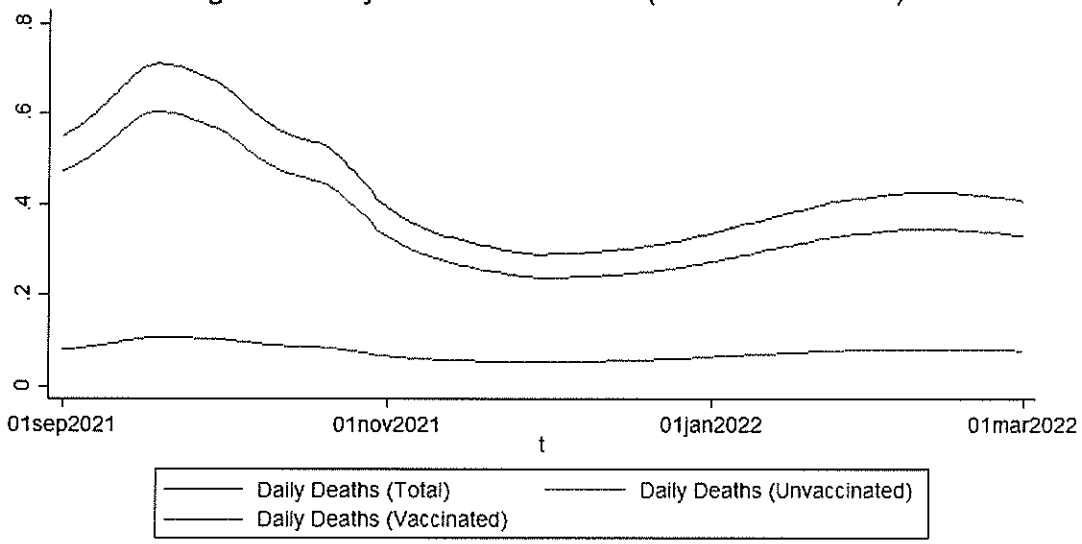
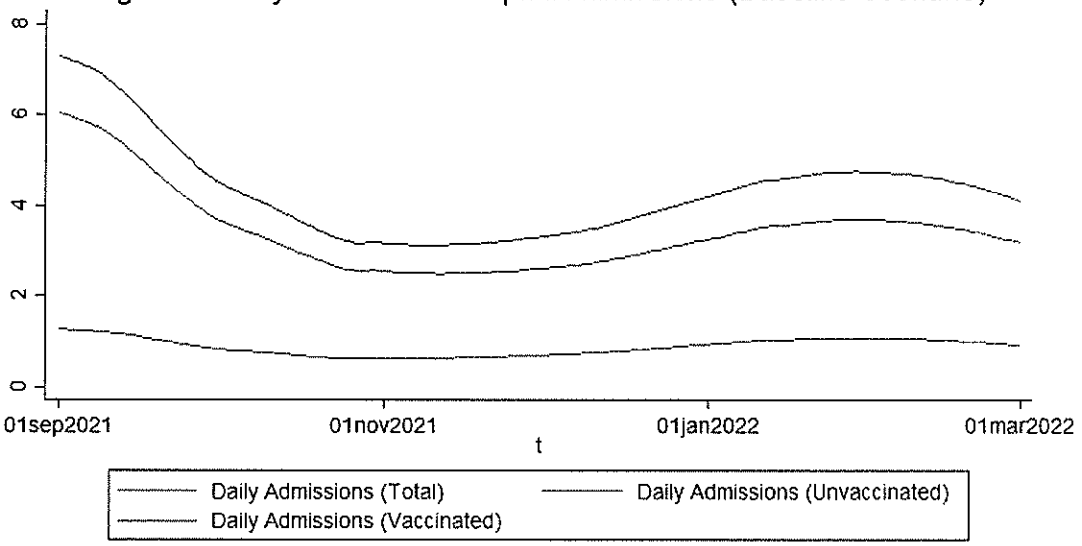


Figure 9: Daily Head Start Hospital Admissions (Baseline Scenario)



Head Start Program Operating Status and Staffing

The Office of Head Start has tracked the operating status of programs since the onset of the pandemic. In March and April of 2020, more than 90% of programs closed all in-person operations. By August of 2020, 21% of programs had reopened for in-person services, 26% remained closed for in-person services due to COVID–19, and the remainder of programs were closed for summer months as regularly scheduled. In December 2020, data show the highest combined percentage (67%) of Head Start centers operating as solely virtual/remote or as hybrid, with an additional 5% of centers closed. Together, these centers account for over 13,500 centers nationwide. This represents many working parents for whom unpredictable closures and transitions to virtual learning come at a cost, present difficult decisions between employment and child care responsibilities, and major financial impacts on their household.

Most recently, July 2021 data show that 2% of centers were closed due to COVID–19, 14% of centers were operating virtual/remote, and 44% of centers were operating in a hybrid status, which includes programs that are alternating between in-person services, virtual or remote services, or some combination of the two. Only 35% of centers were operating fully in-person. We do not have comparable data for about 5% of centers.[115] While closures have declined, the majority of Head Start centers are still operating in virtual/remote or a hybrid status. We adopt these estimates as providing a reasonable representation of the operating status of Head Start centers under the baseline scenario of no regulatory action. These estimates are intended to represent a steady state of overall operating status under the baseline scenario rather than indicating that any particular center will remain in its current status without regulatory action. Table 3 presents the in-person days per week

[115] We are missing data on about 5% of centers. For the purposes of this analysis, we assign an operating status to these centers in proportion with the centers for which we have complete data.

by center status. For these estimates, we adopt several assumptions: (1) The average number of staff and children served by each center does not vary by center status; (2) that centers in hybrid operating status meet in person 2.5 days per week, on average; and (3) that centers in fully in-person status meet in person 5.0 days per week, on average. For the purpose of this analysis, we also assume that the centers with unknown operating status are distributed evenly across each center status category. For our estimate of the total number of children, we use "funded enrollment," which refers to the number of children and pregnant people that are supported by federal Head Start funds in a program at any one time during the program year, but reduce this estimate by 1% to account for pregnant people enrolled in Early Head Start.[116]

Table 3. In-Person Days Per Week by Center Status

Center Status	Centers	Staff	Children	In-Person Days Per Week	In-Person Days Per Week	
					Staff	Children
Closed	414	5,453	17,264	0.0	0	0
Virtual/Remote	3,013	39,698	125,679	0.0	0	0
Hybrid	9,667	127,391	403,305	2.5	318,477	1,008,264
Fully In-Person	7,623	100,458	318,041	5.0	502,292	1,590,204
Total	20,717	273,000	864,289	N/A	820,769	2,598,467

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Early care and education providers, including Head Start programs, are currently experiencing significant challenges in recruiting and retaining staff that are attributable to the COVID–19 pandemic and general trends in early care and education labor markets. These ongoing challenges, which represent the baseline scenario and are not attributable to the interim final rule, are difficult to quantify; however, the section on Costs expands on this discussion. This discussion includes a range of estimates to inform how the requirements in this rule could exacerbate this issue for certain programs, which could include programs not being able to fully staff their classrooms.

E. Impact on Vaccine Coverage

The key parameter underlying the estimated benefits and costs of the interim final rule is the incremental impact on vaccine uptake, which is the difference between the share of individuals who are unvaccinated under the baseline scenario and who are induced to get fully vaccinated under the interim final rule. As we discuss further in the Benefits and Costs sections, higher rates of incremental vaccine uptake are associated with higher benefit estimates, but also lower overall costs. Given the importance of this parameter and its uncertain nature, we perform an analysis of several scenarios for vaccine uptake, and present estimates of the benefits and costs of the interim final rule for each scenario. Each of the scenarios adopt the following timing and simplifying assumptions:

(1) For the purposes of this analysis, we adopt November 22, 2021 as the public announcement date of the interim final rule.

(2) The effective date of the vaccination requirement is January 31, 2022. We anticipate that some Head Start staff will wait until January 31, 2022 to receive their final vaccination dose.

(3) We do not attribute any impact on the rate of fully vaccinated Head Start staff until at least December 6, 2021. The earliest impacts would be among Head Start staff who have received one COVID–19 dose as part of a two-dose series at the time of the public announcement of the interim final rule who are induced by the interim final rule to complete their two-dose series. The latest impacts would be among Head Start staff who receive their final dose on January 31, 2022, who will be considered fully vaccinated two weeks later, on February 14, 2022.

(4) The interim final rule describes exemptions from the vaccination requirement. For the purposes of this analysis, we assume that 5% of total Head Start staff will seek and be granted an exemption from the vaccination requirement.[117] These individuals will not be induced to get fully vaccinated under the interim final rule. This assumption translates to least 13,650[118] Head Start staff who will remain unvaccinated under all vaccine coverage scenarios.

Our upper-bound scenario is based on an observation contained in the HHS *Guidelines for Regulatory Impact Analysis*, which notes that "[i]n most cases, the analysis focuses on estimating the incremental compliance costs incurred by the regulated entities, assuming full compliance with the regulation, and government costs."[119] For the purpose of this analysis, we maintain the assumption that 5% of Head Start staff will seek and be granted an exemption, while the remaining 95% will be fully vaccinated. These represent two of the routes that Head Start staff can demonstrate full compliance with the interim final rule. We note that the HHS *Guidelines for Regulatory Impact Analysis* further recommend that "[a]nalysts should consider the uncertainty associated with an assumption of full compliance and provide analysis of alternative assumptions, as appropriate."

Our lower-bound scenario adopts an estimate drawn from an Issue Brief published by the HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE), which finds that "[a]s of August 2021, approximately 30% of U.S. adults are

[116] *https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/hs-program-fact-sheet-2019.pdf.*

[117] This estimate is consistent with an assumption discussed in the Preamble of the Emergency Temporary Standard recently issued by the Department of Labor's Occupational Safety and Health Administration. "OSHA estimates that some 5% of employees may have a medical contraindication or request an accommodation from the rule's requirements for disability or sincerely held religious belief reasons." *https://www.federalregister.gov/documents/2021/11/05/2021-23643/covid-19-vaccination-and-testing-emergency-temporary-standard.*

[118] 0.05 * 273,000 = 13,650.

[119] *https://aspe.hhs.gov/reports/guidelines-regulatory-impact-analysis.*

unvaccinated; among these, approximately 44% may be willing to get vaccinated against COVID–19." [120] This published finding is based on an analysis using survey data for Week 33 of the Household Pulse Survey (June 23–July 5, 2021). We perform an identical calculation using Week 39 (September 29–October 11) survey responses, which results in a lower estimate of 33.4%. We assume that 33.4% of the unvaccinated individuals will be induced to get fully vaccinated by this time under the policy scenario. Under this scenario, about 86.6% of Head Start staff are fully vaccinated by February 14, 2022.

These estimates are from a nationally representative survey of households, but are broadly consistent with responses from another survey specific to U.S. child care providers.[121] In this survey, which informs our baseline forecast of Head Start staff vaccine coverage, overall vaccine uptake among U.S. child care providers was 78.2%. Among unvaccinated survey respondents, including child care providers not affiliated with Head Start, the authors note that "only 5.0% were 'absolutely certain' that they would get vaccinated in the future, 6.9% were 'very likely,' 28.2% were 'somewhat likely.'" These percentages, which sum to 40.1%, suggest substantial room for additional vaccine uptake among child care providers, even though rates significantly exceeded the general population at the time of the survey. As a sample calculation, if 40.1% of the 21.8% of unvaccinated survey respondents get vaccinated, this would increase the overall vaccine uptake among U.S. child care providers from 78.2% to 86.9%. This estimate is slightly above our lower-bound estimate of vaccine coverage for Head Start staff under the interim final rule.

We anticipate that the vaccination requirement will induce more unvaccinated Head Start staff to get fully vaccinated than the lower-bound vaccine-uptake estimates suggest. For our primary scenario, we adopt the midpoint vaccine coverage rate between our lower- and upper-bound scenarios, and project overall vaccine coverage of 90.8% among Head Start staff by February 14, 2022.

Figure 10 presents our forecasts of the share of Head Start staff who are fully vaccinated under the baseline scenario, and our range of policy scenarios. For our baseline scenario, we estimate the share who are fully vaccinated of 79.8%, or 217,879 fully vaccinated Head Start staff out of 273,000 total staff. We estimate a range of estimates under of our policy scenario between 86.6% and 95.0%, for an incremental vaccine uptake of between 6.8% and 15.2%. For our primary policy scenario, we estimate overall vaccine coverage of 90.8%, for an incremental vaccine uptake of 11.0%. Under the primary scenario, we estimate 247,833 fully vaccinated Head Start staff, and an incremental 29,953 staff fully vaccinated attributable to the interim final rule.

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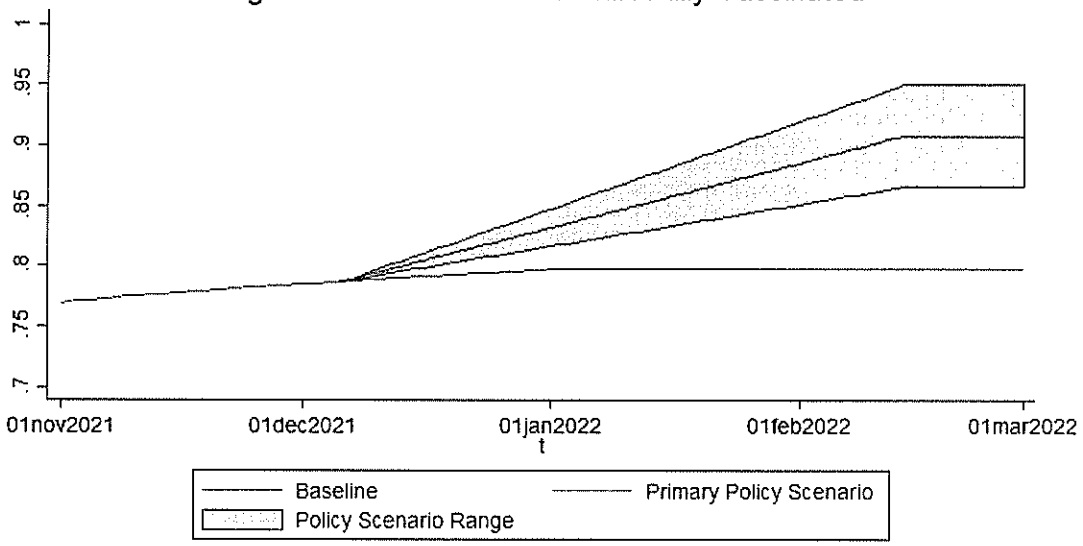
Figure 10: Share of Head Start Fully Vaccinated



E. Benefits of the Rule

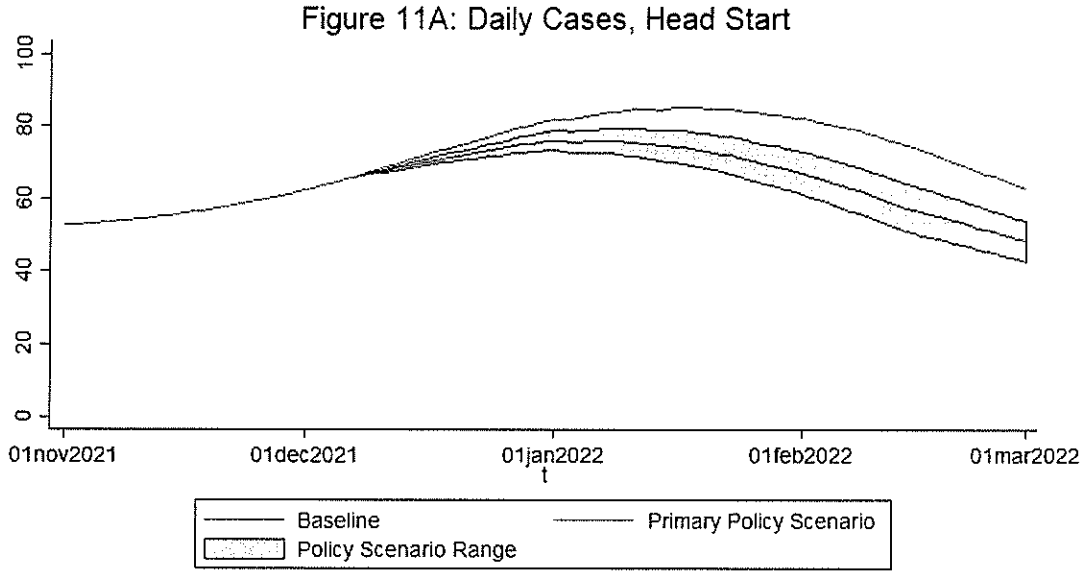
We follow identical procedures outlined in the baseline section to generate forecasts of COVID–19 cases, deaths, and hospitalizations that are consistent with a range of vaccine coverage estimates under the policy scenarios. We estimate the likely impacts of the interim final rule by calculating the difference between the measurable COVID–19 outcomes under the policy scenarios against the baseline scenario described in the previous section.

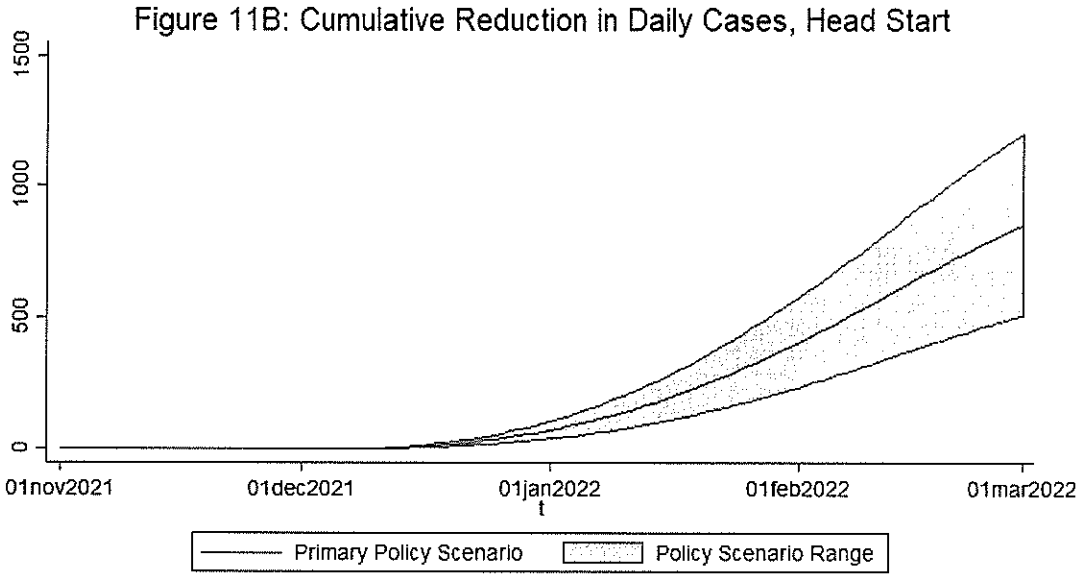
Reduction in Cases Among Head Start Staff

Figure 11A presents our estimates of the daily COVID–19 cases among Head Start staff under each scenario. The baseline scenario corresponds to the estimates presented in Figure 7 in the previous section. Figure 11B presents the cumulative reduction in cases over time that are attributable to the interim final rule under the vaccine coverage scenarios. Through March 1, 2022, the impact of the interim final rule is cumulative COVID–19 case reductions between 510 and 1,198, which correspond to the range of vaccine coverage scenarios.

[120] *https://aspe.hhs.gov/reports/unvaccinated-willing-ib.*

[121] Patel KM, Malik AA, Lee A, et al. (2021). "COVID–19 vaccine uptake among US child care providers." *Pediatrics;* doi: 10.1542/peds.2021–053813.





Reduction in Deaths Among Head Start Staff

Figure 12A presents our estimates of the daily COVID–19 deaths among Head Start Staff under each scenario. The baseline scenario corresponds to the estimates presented in Figure 8 in the previous section. Figure 12B presents the cumulative reduction in deaths over time that are attributable to the interim final rule under the vaccine coverage scenarios. Through March 1, 2022, the impact of the interim final rule is cumulative COVID–19 mortality reductions between 4.8 and 11.2, which correspond to the range of vaccine coverage scenarios.

Figure 12A: Daily Deaths, Head Start

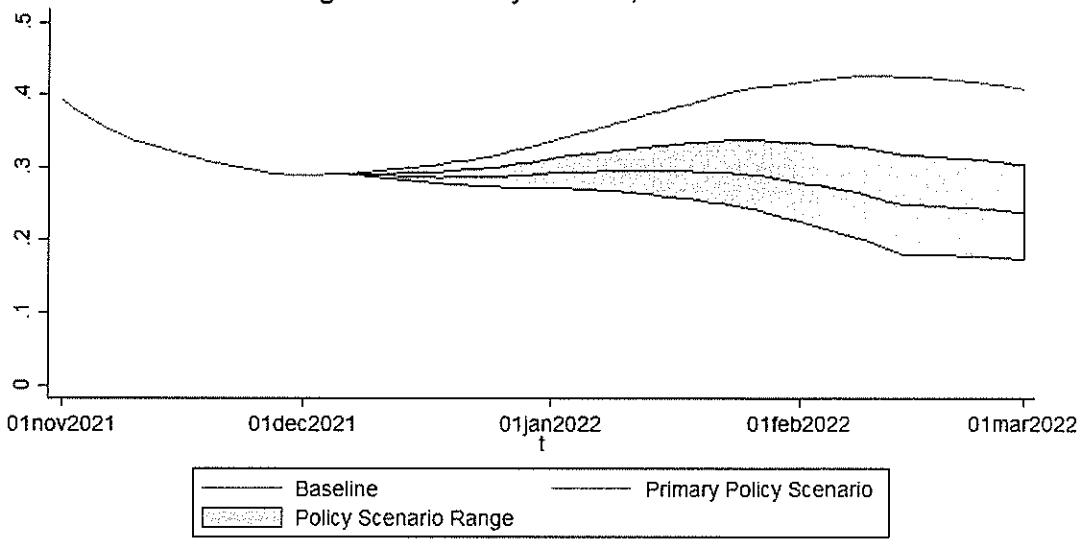
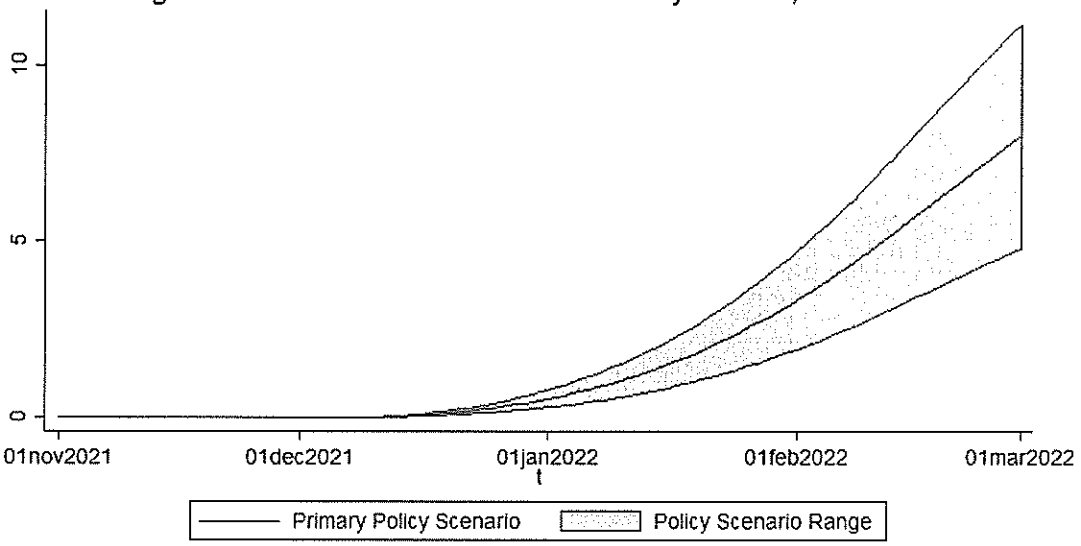
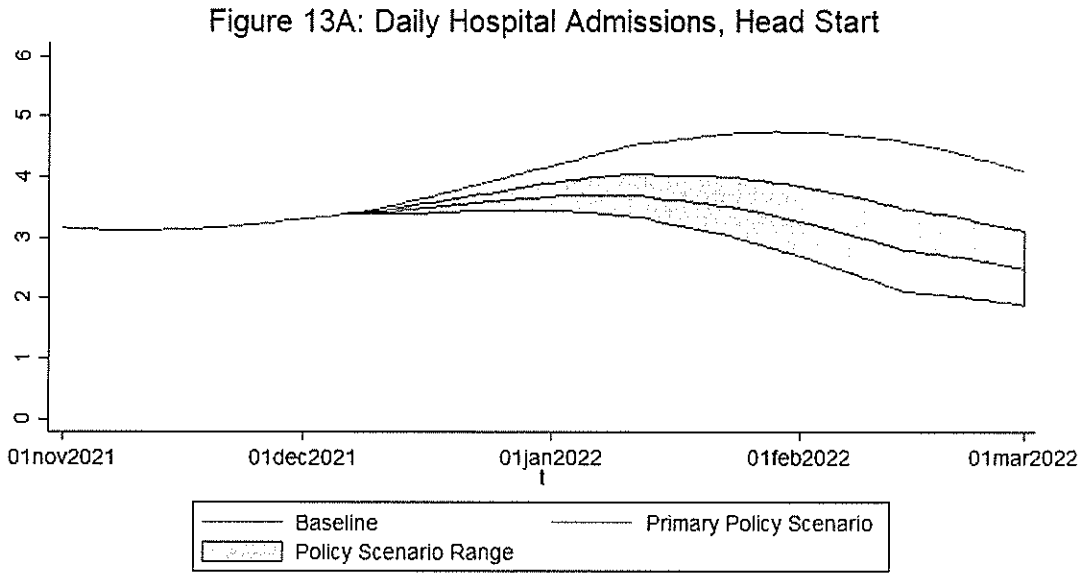


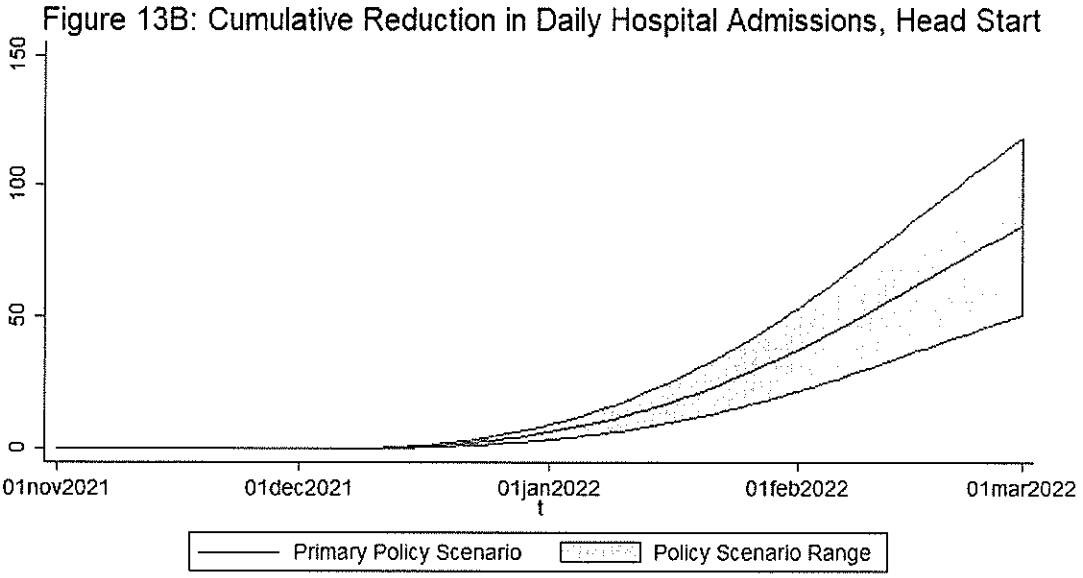
Figure 12B: Cumulative Reduction in Daily Deaths, Head Start



Reduction in Hospital Admissions Among Head Start Staff

Figure 13A presents our estimates of the daily COVID–19 hospital admissions among Head Start Staff under each scenario. The baseline scenario corresponds to the estimates presented in Figure 9 in the previous section. Figure 13B presents the cumulative reduction in hospital admissions over time that are attributable to the interim final rule under the vaccine coverage scenarios. Through March 1, 2022, the impact of the interim final rule is cumulative COVID–19 hospital admission reductions between 51 and 118, which correspond to the range of vaccine coverage scenarios.





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Valuing Health Benefits Among Head Start Staff

Table 3 summarizes several measurable improvements in COVID–19 outcomes for Head Start staff that are attributable to the interim final rule. For the baseline scenario of no new regulatory action, and for each of the vaccine coverage scenarios, we report the share of Head Start staff that are fully vaccinated by March 1, 2022, and the corresponding cumulative cases, deaths, and hospital admissions averted over the time horizon of the analysis.

IHME's daily projections for U.S. hospital admissions include about 35% that result in intensive care unit (ICU) admissions. Head Start hospital admissions estimates are adjusted downwards to reflect a lower rate of hospitalization among younger individuals. We similarly expect the share of hospitalizations that include an ICU admission to be lower for Head Start staff compared to the general adult population; however, we are not aware of an estimate that is directly transferable, and adjust this estimate of the share of hospital admissions that result in an ICU admission down by half. *We believe this assumption is more justified, in the context of this analysis, than not performing an adjustment.* Assuming about 17.5% of the cumulative hospital admissions result in an ICU admission, we estimate 76 ICU admissions under the baseline scenario, and between 55 and 67 ICU admissions under the interim final rule, depending on the vaccine coverage scenario. Therefore, we measure a reduction of between 9 and 21 ICU admissions under the interim final rule. We follow the same approach to calculate non-ICU hospital admissions for the remaining 82.5% of total hospital admissions.

Table 4. Cumulative Impacts Among Staff by Vaccine Coverage Scenario

Outcome	Baseline Scenario	Vaccine Coverage Scenario			Difference		
		Low	Primary	High	Low	Primary	High
Fully Vaccinated Rate	79.8%	86.6%	90.8%	95.0%	6.8%	11.0%	15.2%
Cases	7,724	7,214	6,870	6,526	-510	-854	-1,198
Deaths	37.3	32.4	29.3	26.1	-4.8	-8.0	-11.2
Hospital Admissions	428	377	343	309	-51	-84	-118
Non-ICU	352	310	282	255	-42	-69	-97
ICU	76	67	61	55	-9	-15	-21

Valuing risk reductions associated with regulations that address the COVID–19 presents major challenges. We adopt an approach to monetize the cumulative cases, deaths, and hospitalizations averted under the interim final rule by closely following the methodology described in an ASPE report on "Valuing COVID–19 Mortality and Morbidity Risk Reductions in U.S. Department of Health and Human Services Regulatory Impact Analyses." [122] This paper addresses these challenges by summarizing the impacts of COVID–19 on health and longevity, describing the conceptual framework for valuation, investigating some of the available valuation research (as of March, 2021), and discussing the implications.[123] We note that the impact of the virus is rapidly evolving, and new data are continually emerging. We have reviewed the assumptions and evidence contained in this report and conclude that the quantitative estimates remain useful for assessing the impacts of this interim final rule.

Valuing these risk reductions using the estimates contained in the ASPE report requires assumptions that map the non-fatal risk reductions quantified in Table 4 into "mild," "severe," and "critical" case-severity categories. These categories are characterized by common symptoms experienced for an acute phase and post-acute phase. Below, we reference the description of each case-severity category from Table 3.2 Common Symptoms of Nonfatal COVID–19 Cases by Severity Level of the ASPE Report.[124]

For the acute phase of a critical case, "[i]ndividuals will have early symptoms similar to those of mild and severe disease. Individuals may quickly progress to respiratory failure and may also have septic shock, encephalopathy (brain disease), heart disease or failure, coagulation dysfunction (inability of blood to clot normally), and acute kidney injury. Organ dysfunction can be life-threatening. Individuals with critical disease often receive prolonged mechanical ventilation." For the post-acute phase, "[i]ndividuals are likely to have long-term physical and cognitive impairment similar to other critical illnesses." We initially assign the 9 to 21 averted ICU admissions to the critical case category, but we reduce these estimates by the number of deaths averted. This approach avoids the potential for double counting, since the underlying VSL estimates likely include the willingness-to-pay to avoid some morbidity prior to death.

The ASPE Report discusses these considerations in greater detail, noting that "COVID–19 deaths are generally preceded by about two weeks of symptoms, including fever, shortness of breath, high respiratory rate, and cough. They may also involve being placed on mechanical ventilation in a medically induced coma." This is in contrast to "[t]he studies that underlie the HHS VSL estimates, [which] focus largely on occupational risks that lead to relatively immediate death from injury." Therefore, we explore the sensitivity of the overall results to this approach. Including the value of a critical case to the value of the mortality reductions for these individuals prior to death would increase the total monetized health benefits by between $8.7 million and $20.3 million, depending on the vaccine coverage scenario. We do not include these estimates in the summary of monetized benefits.

For the acute phase of a severe case, "[i]ndividuals will have early symptoms similar to those of mild disease, such as fever and cough, which may be accompanied by gastrointestinal symptoms, such as diarrhea. The disease continues to progress for over a week. Dyspnea (shortness of breath), high respiratory rate, and/or blood oxygen saturation of ≤93 percent occur. Individuals typically have pneumonia and require supplementary oxygen. Individuals with severe disease should be hospitalized." For the post-acute phase, "[i]ndividuals may have post-acute symptoms, such as cough, shortness of breath, fatigue, and pain." We assign the 42 to 97 non-ICU hospital admissions averted to the severe case category.

For the acute phase of a mild case, "[i]ndividuals will have symptoms of acute upper respiratory tract infection, which may include fever, fatigue, myalgia (muscle aches), cough, and sore throat. Some cases may have digestive symptoms, such as nausea, abdominal pain, and diarrhea. Loss of taste and smell are common symptoms. Individuals may have mild pneumonia (infection of the lungs), and some may have wheezing or dyspnea (shortness of breath) but blood oxygen saturation remains above 93 percent." For the post-acute phase, "[i]ndividuals may have post-acute symptoms, such as cough, shortness of breath, fatigue, and pain." We initially assign the 510 to 1,198 cumulative cases averted to the mild case category, but we reduce these estimates by the corresponding estimates of critical and severe cases to avoid double counting. This yields an estimate of between 460 to 1,080 mild cases averted.

[122] *https://aspe.hhs.gov/reports/valuing-covid-19-risk-reductions-hhs-rias.*

[123] Additional relevant citations not contained in the report include Viscusi, W.K. Pricing the global health risks of the COVID–19 pandemic. J Risk Uncertain 61, 101–128 (2020). *https://doi.org/10.1007/s11166-020-09337-2* and Viscusi W.K. Economic lessons for COVID–19 pandemic policies (published online ahead of print, 2021 Mar 4). South Econ J. 2021;10.1002/soej.12492. doi:10.1002/soej.12492.

[124] *https://aspe.hhs.gov/reports/valuing-covid-19-risk-reductions-hhs-rias.* Table 3.2 appears on page 35.

We considered a further adjustment to the estimate range for mild cases to account for the share of cases that are asymptomatic. As noted above, these estimates are derived from projections of *measured COVID–19 cases, rather than total COVID–19 infections.* Over the period of the analysis, these represent slightly less than half of the total projected infections, including those not confirmed through testing. This means that, while our measure of mild cases likely includes some confirmed cases that are asymptomatic, it does not include some symptomatic COVID–19 infections that are not confirmed through testing. The ASPE report also discusses the potential for "cases that are initially asymptomatic or mildly symptomatic may ultimately lead to impaired health over the longer run," suggesting that the VSC estimates for mild cases may underestimate the full long-run health-related quality of life consequences of an infection. Given the multiple sources and potential direction of the bias, we have determined that it is appropriate to not make an explicit adjustment. However, we have incorporated uncertainty into the main analysis, which includes a range of total cases averted. We also perform a sensitivity analysis for all health benefits monetized in this analysis by applying a range of VSC and VSL estimates.

The mortality and morbidity risk reductions we identify in this regulatory impact analysis accrue to a working-age Head Start staff population. We have taken care to ensure that our estimates of the cumulative cases, deaths, and hospital admissions averted would not be biased upwards due to an overrepresentation of deaths and hospital admissions among individuals older than the typical Head Start staff. Thus, we adopt the population-average VSL and VSC estimates contained in the ASPE report, with a minor adjustment of 0.8% to account for real income growth, since the mortality and morbidity risk reductions occur in 2021 and the underlying estimates are from a 2020 base year.

Table 5A reports the mortality risk reductions attributable to the interim final rule, and the morbidity risk reductions, categorized by case-severity category. We monetize these impacts using a VSL of about $11.5 million, and VSC estimates that vary by case severity. We multiply the risk reductions by the appropriate VSL or VSC estimate to generate estimates of the value of these risk reductions. We sum these to generate a monetized benefit of the health benefits to Head Start staff attributable to the interim final rule under the vaccine coverage scenarios. Using a 3% discount rate, which affects the underlying value per quality-adjusted life year estimate used in the ASPE report to generate the VSC estimates, we report a total value of risk reduction of between $66.0 million and $154.1 million. Table 5B reports the same estimates using a 7% discount rate. Under this discount rate, we report a total value of risk reduction of between $68.2 million and $159.2 million. All estimates are reported using 2020 dollars. These impacts cover the period between the publication date of the interim final rule and March 1, 2022, the last day reported in the IHME projections.

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Table 5A. Value of COVID-19 Risk Reductions Among Staff, 3% Discount Rate

Risk Reduction	Vaccine Coverage Scenario			VSL or VSC	Value of Risk Reduction ($ millions)		
	Low	Primary	High		Low	Primary	High
Mortality Reductions	4.8	8.0	11.2	$11,501,365	$55.2	$92.0	$128.8
Morbidity Reductions							
Mild Cases	459.8	769.8	1,079.7	$5,846	$2.7	$4.5	$6.3
Severe Cases	41.6	69.4	97.2	$13,104	$0.5	$0.9	$1.3
Critical Cases	4.2	7.0	9.8	$1,814,400	$7.6	$12.7	$17.7
Total Value of Risk Reductions					$66.0	$110.1	$154.1

Table 5B. Value of COVID-19 Risk Reductions Among Staff, 7% Discount Rate

Risk Reduction	Vaccine Coverage Scenario			VSL or VSC	Value of Risk Reduction ($ millions)		
	Low	Primary	High		Low	Primary	High
Mortality Reductions	4.8	8.0	11.2	$11,501,365	$55.2	$92.0	$128.8
Morbidity Reductions							
Mild Cases	459.8	769.8	1,079.7	$9,778	$4.5	$7.5	$10.6
Severe Cases	41.6	69.4	97.2	$22,176	$0.9	$1.5	$2.2
Critical Cases	4.2	7.0	9.8	$1,814,400	$7.6	$12.7	$17.7
Total Value of Risk Reductions					$68.2	$113.7	$159.2

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Valuing Time Savings for Head Start Families From Reductions in Absenteeism

We also anticipate reductions in time spent by parents or other caretakers providing needed support for children due to COVID–19 infections among Head Start staff. Several assumptions are necessary to quantify this impact. Since 273,000 Head Start staff provide services for 864,289 children, a 1:3.2 ratio, we assume that each staff missing work due to a COVID–19 infection means that an average of 3.2 children will need support from parents or other caretakers during this absence. We assume that a typical COVID–19 case results in two weeks of missed work, which corresponds to an average of 5 days a week, with 6 hours per day of providing Head Start services. Combining these assumptions, we estimate that cases of COVID–19 among Head Start staff results in an average of 190 hours of support for children that will be provided by a parent or other caretaker. *As discussed earlier, the interim final rule is anticipated to reduce COVID–19 cases among Head Start staff by a cumulative 510 to 1,198 cases over the time horizon of the analysis. Each of these cases averted corresponds to 190 hours of time saved by parents or other caregivers.*

We also anticipate that a COVID–19 case at a center operating fully in-person can result in missed work for other Head Start staff who were in close contact and potentially exposed. This impact is limited to unvaccinated staff, since CDC guidance indicates that "[p]eople who are fully vaccinated do not need to quarantine if they come into close contact with someone diagnosed with COVID–19." [125] We assume that all unvaccinated staff will be considered close contacts and need to quarantine. For simplicity, we adopt 20.2% as the share of Head Start staff unvaccinated on the last day of our baseline projections. We anticipate that Head Start staff at fully in-person centers represent 37% of the total staff cases, which is in line with the share of centers that are operating fully in-person, and that each center has about 13 staff, which is in line with the average number of staff per center. Among these 13 staff, about 3 are unvaccinated. To avoid double counting, we reduce this estimate by 1 to account for the initial COVID–19 case.

To monetize these impacts, we adopt a value of time based on after-tax wages. Our approach matches the default assumptions for valuing changes in time use for individuals undertaking administrative and other tasks on their own time, which are outlined in an ASPE report on "Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices." [126] We start with a measurement of the usual weekly earnings of wage and salary workers of $990.[127] We divide this weekly rate by 40 hours to calculate an hourly pre-tax wage rate of $24.75. We adjust this hourly rate downwards by an effective tax rate of about 17%, resulting in a post-tax hourly wage rate of $20.55. We report a range for the total value of time saved of between $3.3 million and $7.5 million, depending on the vaccine coverage scenario.

[125] *https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-contact-tracing/about-quarantine.html.*

[126] *https://aspe.hhs.gov/reports/valuing-time-us-department-health-human-services-regulatory-impact-analyses-conceptual-framework.*

[127] *https://www.bls.gov/news.release/pdf/wkyeng.pdf, second quarter of 2021.*

Table 6. Value of Time Savings from Reduced Absenteeism

Impact	Low	Primary	High
Cases Averted	510	854	1,198
Cases Averted at In-Person Centers	188	314	441
Unvaccinated Close Contacts	1.7	1.7	1.7
Additional Quarantines Averted	312	522	732
Total Absences Averted	822	1,376	1,930
Hours Saved Per Absentee	190	190	190
Total Hours Saved	156,198	261,406	366,614
Value of Time in Hours	$20.55	$20.55	$20.55
Value of Reduced Absenteeism	$3,210,121	$5,372,304	$7,534,486

As a sensitivity analysis, we augmented the post-tax wage rate to account for non-wage benefits. To capture non-wage benefits, we apply an estimate of the share of compensation from employer supplements to wages and salaries of about 18%, or $4.55 per hour using a pre-tax hourly wage as the base.[128] This results in a value of time of $25.10 per hour. Using this alternative value of time, the value of time savings from reduced absenteeism would range from $3.9 million to $9.2 million, with a primary estimate of $6.6 million.

Benefits Related to Head Start Program Operating Status

We consider it probable that the substantial reduction in COVID–19 cases per day among Head Start staff and volunteers will result in fewer center closures due to COVID–19. For a number of reasons, the interim final rule will not eliminate the risk of COVID–19 among Head Start staff, volunteers, and children. Among these reasons, we do not expect that all staff and volunteers will be fully vaccinated under the interim final rule. We also do not expect many children to be fully vaccinated under either the baseline or any of the vaccine coverage scenarios under the policy for the time horizon of the analysis. As described in our discussion of the baseline scenario, being fully vaccinated is associated with a substantial reduction in the risk of a COVID–19 infection; however, it does not eliminate this risk. Thus, since the interim final rule will not eliminate the risk of COVID–19, we cannot reasonably conclude that all currently closed Head Start centers will reopen and remain open for the time horizon of the analysis. We do not estimate the reduction in closures anticipated due to the interim final rule; however, we present a calculation of how we would value this impact on a per-center basis.

As discussed in the Baseline section, the most recent data available at the time of this analysis indicates that 393 Head Start centers were closed due to COVID–19, representing about 2% of centers. We also presented an estimate of 17,264 children potentially unable to access Head Start services due to these closures, which is about 42 children per center. We restate the assumption that each child not served by these centers requires 30 hours of support per week from family and caregivers that would normally be provided by Head Start staff and volunteers. This means each center closure results in 1,318 hours of support needed per week that would typically be provided by Head Start staff. Combined with the approach to valuing time described earlier, this means each center closure averted by the interim final rule could result in time saved for parents and caregivers valued at $25,722 per week. If 1% of total Head Start centers reopen as a result of the interim final rule, we would monetize these benefits at $5.3 million per week.

We also anticipate that the reduction in COVID–19 infection risks among Head Start staff, paired with the mask requirement, will result in a larger share of centers operating fully in person. As discussed in the Baseline section, 3,013 centers are operating in a virtual/remote status and 9,667 centers are operating in a hybrid status. We estimate that 125,679 children are receiving services in centers operating in a virtual/remote status and that 403,305 children are receiving services in centers operating in a hybrid status. We anticipate that centers transitioning from virtual/remote status to hybrid status, or from hybrid status to fully in-person status could result in time saved for parents and caregivers. We do not provide an estimate, but we expect the value of time saved for these impacts would be less than the value of time saved from reopening closed centers.

The value of time saved for families due to Head Start centers reopening, centers transitioning from virtual/remote status to hybrid status, and centers transitioning from hybrid status to fully in-person status are likely to be substantial. However, these time savings are only part of the anticipated benefits to children and families as the result of fewer closures, and more in-person services. *Head Start* promotes school readiness for children in low-income families by offering educational, nutritional, health, social, and other services. We expect that Head Start centers that are able to reopen or move towards more in-person services under the interim final rule will be more effective in meeting these goals and the needs of Head Start families.

Valuing Health Benefits Among Head Start Volunteers

The interim final rule requires volunteers that interact with children at Head Start programs to be fully vaccinated. In 2019, approximately 1,061,000 adults volunteered in their local Head Start program. Of these, 749,000 were parents of Head Start

[128] *https://fredblog.stlouisfed.org/2018/10/employer-contributions/.*

children.[129] We have less information about these adults than for Head Start staff. For the purposes of providing estimates under the baseline and interim final rule, we make the following assumptions:

1. The baseline vaccine coverage rate for Head Start volunteers matches the overall adult vaccine coverage rate.

2. The mortality and morbidity risks for adult Head Start volunteers match the risks for Head Start staff, except through differences in vaccine coverage.

3. The requirement under the interim final rule will be less salient to unvaccinated volunteers than for staff since it is not linked to employment. We start with the lower-bound incremental vaccine-uptake estimate that, among unvaccinated adults, approximately 33.4% will be induced to get fully vaccinated. As discussed earlier, this estimate is based on an analysis of the Household Pulse Survey. We reduce this estimate by half, which is similar to excluding adults who are "unsure about getting a vaccine," and results in an incremental vaccine-uptake estimate of about 16.7%.

4. The volunteers most likely to be impacted by the policy are the volunteers associated with centers operating under a hybrid or fully in-person status. For volunteers at centers that are closed or in a virtual/remote operating status, we adopt an incremental vaccine-uptake of 0%.

5. We assume that the requirement will be even less salient for volunteers associated with centers operating in hybrid status. For these volunteers, we further reduce the incremental vaccine-uptake estimate by half, which is similar to excluding adults who "will probably get a vaccine." This results in an incremental-vaccine uptake of about 8.4%.

6. We do not estimate a second incremental vaccine-uptake scenario, such as the upper-bound full-compliance scenario for staff, since volunteers can comply with the requirement by choosing to not interact with children in an in-person Head Start setting. We also note that some of these volunteers may be induced to get vaccinated due to another COVID–19 vaccination requirement.

7. For the purposes of this analysis, we assume that volunteers are distributed evenly across Head Start centers, regardless of operating status.

Table 7 summarizes these assumptions for the number of volunteers, and the incremental vaccine-uptake assumptions that vary by center operating status.

Table 7. Vaccine Uptake Among Head Start Volunteers by Center Status

Center Status	Centers	Volunteers	Vaccine-Uptake Assumption
Closed	414	21,193	0.0%
Virtual/Remote	3,013	154,283	0.0%
Hybrid	9,667	495,097	8.4%
Fully In-Person	7,623	390,426	16.7%
Total	20,717	1,061,000	N/A

We follow identical steps for estimating the baseline scenario and policy scenario for Head Start staff, except to substitute the number of volunteers and vaccine-uptake assumptions for each center operating status category. As noted above, we also assume that the baseline vaccination coverage among volunteers matches the adult vaccination coverage, rather than the higher Head Start staff vaccination coverage.

Table 8 summarizes several measurable improvements in COVID–19 outcomes for Head Start volunteers at centers operating fully-in person that we attribute to the interim final rule. We estimate a total increase of 28,163 volunteers who are fully vaccinated, or about 2.7% of the total volunteers. To put this into the context of other vaccine requirements and to continue the discussion of attribution of impacts, we consider the Head Start volunteers under the baseline scenario who are also covered by the DOL ETS as employees of covered employers. DOL recently estimated 27.0% of covered employees would be vaccinated under the ETS, not including the 62.4% of covered employees vaccinated in the baseline, pre-ETS.[130] If every Head Start volunteer was covered by this interim final rule, the DOL ETS as an employee of a covered employer, and no other vaccine requirements, our 2.6% estimate would attribute about 10% of the incremental vaccine coverage to this interim final rule and about 90% to the DOL ETS. As a sensitivity analysis on the appropriate attribution of impacts, we also report the net benefits of the interim final rule, excluding all benefits and costs associated with volunteers. These estimates are identical to the policy alternative of not including volunteers in the scope of the policy, which appears in Table 26.

For the baseline scenario of no new regulatory action, and for interim final rule scenario, we report the share of these volunteers that are fully vaccinated by March 1, 2022, and the corresponding cumulative cases, deaths, and hospital admissions averted over the time horizon of the analysis. Table 9 presents the same estimates for Head Start volunteers associated with centers in hybrid operating status. Table 10 presents the same estimates that combine Head Start volunteers associated with centers in virtual/remote and closed operating statuses. Table 11 presents the estimates for all Head Start volunteers.

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[129] *https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/hs-program-fact-sheet-2019.pdf.*

[130] *https://www.govinfo.gov/content/pkg/FR-2021-11-05/pdf/2021-23643.pdf.* Table IV.B.8.

Table 8. Impacts Among Volunteers at In-Person Centers

Outcome	Baseline	Interim Final Rule	Difference
Fully Vaccinated Rate	73.8%	78.2%	4.4%
Cumulative Cases	10,368	10,035	-333
Cumulative Deaths	130.1	122.9	-7.2
Cumulative Hospital Admissions			
Non-ICU	731	693	-37
ICU	158	150	-8
Total	888	843	-45

Table 9. Impacts Among Volunteers at Hybrid Centers

Outcome	Baseline	Interim Final Rule	Difference
Fully Vaccinated Rate	73.8%	76.0%	2.2%
Cumulative Cases	13,421	13,273	-148
Cumulative Deaths	170.6	167.2	-3.4
Cumulative Hospital Admissions			
Non-ICU	957	940	-17
ICU	206	203	-4
Total	1,163	1,142	-21

Table 10. Impacts Among Volunteers at Virtual/Remote and Closed Centers

Outcome	Baseline	Interim Final Rule	Difference
Fully Vaccinated Rate	73.8%	73.8%	0.0%
Cumulative Cases	5,599	5,599	0
Cumulative Deaths	71.9	71.9	0
Cumulative Hospital Admissions			
Non-ICU	400	400	0
ICU	86	86	0
Total	486	486	0

Table 11. Impacts Among All Head Start Volunteers

Outcome	Baseline	Interim Final Rule	Difference
Cumulative Cases	29,388	28,907	-481
Cumulative Deaths	372.6	362.1	-10.6
Cumulative Hospital Admissions			
Non-ICU	2,087	2,033	-55
ICU	450	438	-12
Total	2,538	2,471	-66

We value the mortality and morbidity risk reductions experienced by Head Start volunteers following an identical methodology described above for Head Start staff. This includes the process for categorizing morbidity reductions by case-severity category, and the adjustments to prevent double counting. Table 12 presents the total value of COVID–19 mortality and morbidity risk reductions for Head Start volunteers across all centers, for a 3% discount rate, *which affects the value per quality-adjusted life year estimates underlying the VSC estimates. Table 13 presents the same estimates for a 7% discount rate.*

Table 12. Value of COVID-19 Risk Reductions Among Volunteers, 3% Discount Rate

Risk Reduction	Impact	VSL or VSC (3%)	Value of Risk Reduction
Mortality Reductions	10.6	$11,501,365	$121,440,804
Morbidity Reductions			
Mild Cases	414	$5,846	$2,422,527
Severe Cases)	54.5	$13,104	$714,294
Critical Cases	1.2	$1,814,400	$2,176,442
Total Value of Risk Reductions			$126,754,066

Table 13. Value of COVID-19 Risk Reductions Among Volunteers, 7% Discount Rate

Risk Reduction	Impact	VSL or VSC (7%)	Value of Risk Reduction
Mortality Reductions	10.6	$11,501,365	$121,440,804
Morbidity Reductions			
Mild Cases	414	$9,778	$4,051,467
Severe Cases	54.5	$22,176	$1,208,805
Critical Cases	1.2	$1,814,400	$2,176,442
Total Value of Risk Reductions			$128,877,518

Summary of Monetized Benefits

We identify several sources of monetized benefits that are attributable to the interim final rule. Table 14 reports the monetized benefits from mortality and morbidity risk reductions to Head Start staff, mortality and morbidity risk reductions to Head Start volunteers, and time savings for parents and caregivers. These estimates cover both Head Start staff vaccination coverage scenarios, and correspond to VSC estimates using a 3% discount rate. All estimates cover the time period between the publication of the interim final rule and March 1, 2022, and are reported in 2020 dollars. Table 15 reports the same estimates using a 7% discount rate.

Table 14. Monetized Benefits Attributable to the Interim Final Rule, 3% Discount Rate

Value of Impact	Low	Primary	High
COVID-19 Risk Reductions, Staff	$66,021,974	$110,059,221	$154,096,444
COVID-19 Risk Reductions, Volunteers	$126,754,066	$126,754,066	$126,754,066
Absenteeism Reductions	$3,210,121	$5,372,304	$7,534,486
Total Monetized Benefits	$195,986,161	$242,185,591	$288,384,996

Table 15. Monetized Benefits Attributable to the Interim Final Rule, 7% Discount Rate

Value of Impact	Low	Primary	High
COVID-19 Risk Reductions, Staff	$68,206,983	$113,715,169	$159,223,331
COVID-19 Risk Reductions, Volunteers	$128,877,518	$128,877,518	$128,877,518
Absenteeism Reductions	$3,210,121	$5,372,304	$7,534,486
Total Monetized Benefits	$200,294,622	$247,964,991	$295,635,335

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In addition to the impacts that we monetize in this analysis, we anticipate that the increase in vaccine coverage attributable to the interim final rule will result in indirect health benefits from reduced transmission of SARS–COV–2. These impacts include reductions in secondary infections from vaccinated Head Start staff and volunteers to other staff and volunteers, children, and families. We anticipate that the masking requirement will also reduce transmission at in-person Head Start settings from individuals covered by the requirement. This impact includes a reduction in COVID–19 transmission from children to Head Start teachers, staff, and other children. The reductions in transmission attributable to the interim final rule will result in additional, unquantified reductions in mortality and morbidity risks to Head Start children and families, and to the general public.

We request comment on potential quantitative estimation of benefits for Head Start staff who receive exemptions (associated with ancillary provisions and reduced exposure when colleagues are vaccinated) using a study by Chen, Glymour, et al. (2021).[131] In this paper, estimates of excess mortality among 18- to 65-year-olds in California during the eight months from March to October, 2020, are summarized across various industry categories, including teacher assistants, for whom the estimated ratio is 1.28.[132] The "unemployed or missing [employment data]" category has an excess mortality risk ratio of 1.23—which may yield a reasonable estimate of the new risk level in cases of rule-induced staff turnover. During most of the eight months covered by the Chen et al. study, California imposed stay-at-home requirements, but these policies were relaxed somewhat during the early and mid-summer, the result being an increase in COVID–19 mortality. Visual inspection of Chen et al.'s Figure 2 allows for estimation analogous to that described above, using the excess mortality risk ratios for August 1, and yielding a result that the scope for workplace safety improvements is lesser in the context of relatively free movement and activity, as compared with a situation of broader non-workplace mitigation measures. In other words, whatever the overall effectiveness of Cal/OSHA's workplace health and safety requirements—presumably similar to this IFR's ancillary provisions—it should be reduced substantially when extrapolated to a context without widespread stay-at-home policies. An additional tendency toward overstatement in the potential estimation approach exists because it does not incorporate a netting off of the impacts of other jurisdictions'—including California's own—mitigation activities. (In other words, it would be necessary to use the correct baseline before attributing benefits to this IFR.) By contrast, this suggested quantification method has a tendency toward underestimation in that it does not account for reduction in exposure due to exemption-receiving Head Start staff being surrounded by colleagues who are more widely vaccinated. In addition to seeking comment on how to address these challenges in a potential quantitative estimate of benefits for exemption recipients, we request feedback on the potential to use literature such as Chen, Glymour et al. to proxy the new risk level for non-turnover cases.

F. Costs of the Rule

The most significant cost of the interim final rule stems from the potential for Head Start staff to decline COVID–19 vaccination. This would result in a number of potential consequences, each of which is likely to represent a substantial social cost. Table 16 presents the number of Head Start staff anticipated to be fully vaccinated under the vaccine coverage scenarios, under a shared assumption that 5% of Head Start staff will seek and receive an exemption from the vaccination requirement. Under the lower-bound vaccine coverage scenario, as many as

[131] Chen, Yea-Hung, Maria Glymour, Alicia Riley, John Balmes, Kate Duchowny, Robert Harrison, Ellicott Matthay, Kirsten Bibbins-Domingo. "Excess mortality associated with the COVID–19 pandemic among Californians 18–65 years of age, by occupational sector and occupation: March through October 2020." medRxiv 2021.01.21.21250266; doi: *https://doi.org/10.1101/2021.01.21.21250266.*

[132] The list of occupations with specific estimates differs, omitting teacher assistants, in a subsequent version of the paper. Chen, Yea-Hung, Maria Glymour, Alicia Riley, John Balmes, Kate Duchowny, Robert Harrison, Ellicott Matthay, Kirsten Bibbins-Domingo. "Excess mortality associated with the COVID–19 pandemic among Californians 18–65 years of age, by occupational sector and occupation: March through November 2020." *PLoS One*, June 4, 2021 *https://doi.org/10.1371/journal.pone.0252454.*

23,035 Head Start staff will not meet the vaccination requirement and also not receive an exemption. The upper-bound vaccine coverage scenario reflects all Head Start staff that do not meet the vaccination requirement receiving an exemption. Under our primary scenario, 11,517 Head Start Staff will not meet the vaccination requirement and also not receive an exemption from the vaccination requirement.

Table 16. Head Start Staff COVID-19 Vaccine Requirement Response Possibilities

Outcome Under Policy Scenario	Low	Primary	High
Fully Vaccinated Rate	86.6%	90.8%	95.0%
Exemption Rate	5.0%	5.0%	5.0%
Compliance Rate, Pre-Turnover	91.6%	95.8%	100.0%
Head Start Staff in Compliance, Pre-Turnover	249,965	261,483	273,000
Potential Head Start Staff Turnover	23,035	11,517	0

We anticipate some staff employed by Head Start programs will choose to leave the program due to vaccination and mask mandates. There are already significant challenges in recruiting and retaining staff among early care and education providers including Head Start and the requirements in this rule could exacerbate this issue for certain programs, resulting in programs not being able to fully staff their classrooms. This could also result in costs to programs to recruit new qualified staff to replace those staff that leave the program and may result in interruption of services for children and families.

Costs Associated With Head Start Staff Vacancies

In this section, we describe our approach for valuing the costs associated with Head Start staff vacancies associated with quitters that are attributable to the interim final rule. We follow many of the assumptions contained in the Benefits section that outline the value of time savings for parents and caretakers of children attributable to the interim final rule through vaccine coverage and reduced COVID–19 cases among Head Start teachers. For each COVID–19 case averted, parents and caretakers experienced 190 hours of time savings, assuming each COVID–19 case lasts two weeks. To value the countervailing risk of staff vacancies, we adopt an assumption that each Head Start staff that quits in response to the interim final rule will leave a vacancy that lasts an average of two weeks. This assumption is intended to reflect an average duration among vacancies that are filled faster and vacancies that are filled slower than two weeks. It is also intended to be inclusive of any efforts by Head Start centers that anticipate resignations on the effective date of the policy to identify replacements when the vaccine requirement takes effect. We also anticipate that Head Start centers will be able to prepare in advance for these vacancies and reduce the impact on families through increased caseloads per staff. This preparation would not be possible for absenteeism due to a COVID–19 case or outbreak. We reduce the average number of families affected by half, which results in an overall estimate of about 95 hours of time costs for parents and caretakers of children receiving Head Start services per vacancy from resignations. We are not aware of another estimate of how long a typical vacancy of this nature lasts; however, given that we anticipate this to be a significant cost attributable to the interim final rule, we have determined that these assumptions are more justified, in the context of this analysis, than not monetizing this cost. We acknowledge significant uncertainty in several of these estimates and discuss the nature of and implications of each source.

We also include a cost of training the replacement Head Start staff. We assume that new-employee training takes an average of 40 hours, and we adopt a value of time based on the median wage rage of preschool and kindergarten teachers of $14.36 per hour.[133] We double this wage to generate a fully loaded wage that accounts for benefits and other indirect costs. Table 17 reports the costs of vacancies and costs of training under the vaccine coverage scenarios.

[133] *https://www.bls.gov/oes/current/naics4_624400.htm.*

Table 17. Costs of Staff Vacancies

Impact	Low	Primary	High
Vacancies	23,035	11,517	0
Hours per Vacancy	95	95	95
Total Hours	2,187,747	1,093,873	0
Value of Time	$20.55	$20.55	$20.55
Subtotal, Vacancy Costs	$44,961,638	$22,480,819	$0
Hours Training			
Replacements	40	40	40
Value of Time	$28.72	$28.72	$28.72
Subtotal, Training Costs	$26,462,078	$13,231,039	$0
Total	$71,423,717	$35,711,858	$0

Table 17 presents cost estimates that vary by the vaccine coverage scenarios, which directly impact the number of vacancies that we attribute to the interim final rule. For these calculations, we adopt a common estimate of two weeks for Head Start centers to fill these vacancies. As noted in the baseline section, early care and education providers are currently experiencing significant challenges in recruiting and retaining staff that are attributable to the COVID–19 pandemic and general trends in early care and education labor markets. The general trends in early care and education labor markets suggest that filling these vacancies could take longer than two weeks. However, the interim final rule directly addresses the risk of SARS–COV–2 transmission at Head Start centers. The vaccination and masking requirements might lead to new hiring of employees who would not feel safe working in these environments absent these rules. This effect would reduce the average time to fill each vacancy. Alternatively, this could represent an additional source of benefits not captured in the main analysis elsewhere.

These cost estimates reflect one approach to account for the cost of staff vacancies. Other approaches may be reasonable. For example, in the context of its interim final rule with comment period that requires COVID–19 vaccinations for workers in most health care settings that receive Medicare and Medicaid reimbursement, CMS calculates the likely magnitude of hiring costs by applying an analysis of the direct hiring costs for workers in the long-term care sector.[134] After updating for inflation, CMS reports a direct hiring cost of $4,000 per worker.[135] The total cost estimates in Table 17 amount to $3,100 per worker. Substituting CMS's per-worker estimate would result in a range of total cost estimates from $0 to $92 million, with a central estimate of $46 million.

The cost of staff vacancies estimates also reflect an estimate of the value of time of $20.55 per hour, which we also use to estimate the benefits from reduced absenteeism. In a sensitivity analysis for those benefits, we applied a higher value of time of $25.10. Performing an identical sensitivity analysis for these costs yield a higher central estimate of vacancy costs of $27.5 million, which is a $5.0 million increase compared to the estimate in Table 17. This value of time would also yield a higher estimate of vacancy costs under the low-coverage scenario of $54.9 million, which is a $10.0 million increase compared to the estimate in Table 17.

In addition to the costs we identify and monetize related to staff vacancies, we also note the potential costs associated with reduced support from volunteers. However, as with staff, it is also conceivable that some individuals who do not currently feel safe volunteering at in-person Head Start settings will feel comfortable volunteering under the interim final rule. On net, this could increase the support Head Start centers receive from volunteers.

Cost to Head Start Staff and Volunteers to Get Fully Vaccinated

We identify a second cost related to Head Start staff and volunteers getting fully vaccinated. We adopt an estimate of 2 hours as the time necessary to receive one COVID–19 vaccine dose, and adopt a simplifying assumption that each individual induced to get fully vaccinated under the interim final rule will receive two vaccine doses. This estimate is intended to be inclusive of scheduling time; commuting time; time receiving a vaccine dose; waiting time, including after receiving a vaccine dose to watch for any reactions; and recovery time. We value the time spent to get fully vaccinated using a $20.55 per hour value of time, described above, for a total value of time per person of about $82. We also include costs associated with the vaccine doses and costs of administration. Using an estimated $20 cost per dose of vaccine, $20 as the cost per vaccine administration, we compute the cost of vaccine doses and administration of $80 per person. Table 18 reports the total costs related to vaccination.

[134] Dorie Seavey, "The Cost of Frontline Turnover in Long-Term Care," Better Jobs Better Care Report, Washington, DC: Institute for the Future of Aging Services, American Association of Homes and Services for the Aging. 2004

[135] *https://www.govinfo.gov/content/pkg/FR-2021-11-05/pdf/2021-23831.pdf.*

Table 18. Costs Related to Vaccination

Cost Element	Low	Primary	High
Additional Staff Vaccinated	18,436	29,953	41,470
Additional Volunteers Vaccinated	28,163	28,163	28,163
Hours to Receive One Dose	2	2	2
Doses per Person	2	2	2
Value of Time in Hours	$20.55	$20.55	$20.55
Value of Time per Person	$82	$82	$82
Subtotal, Value of Time for Staff	$1,515,532	$2,462,324	$3,409,116
Subtotal, Value of Time for Volunteers	$2,315,203	$2,315,203	$2,315,203
Cost per Dose of Vaccine	$20	$20	$20
Cost per Vaccine Administration	$20	$20	$20
Doses per Person	2	2	2
Cost of Vaccine Doses and Administration per Person	$80	$80	$80
Subtotal, Vaccine Doses and Administration	$3,727,923	$4,649,305	$5,570,686
Total Costs of Vaccination	$7,558,658	$9,426,831	$11,295,005

The costs related to vaccination reflect an estimate of the value of time, $20.55 per hour, used elsewhere in this analysis. In other cases where this value of time is applied, we have also performed a sensitivity analysis that applies a higher value of time of $25.10. Performing an identical sensitivity analysis for these costs yields a value of time per person to get vaccinated of about $100. This higher value of time results in total costs of between $8.4 million and $12.6 million, with a central estimate of $10.5 million, which is an increase of between $0.8 million and $1.3 million. Regardless of the chosen value of time, the costs in Table 18 may be underestimated, since they do not include costs associated with adverse events reported after COVID–19 vaccination.[136]

Cost of Masking

This regulation also requires mask wearing for all adults and children age 2 and older in certain in-person Head Start settings. As an intermediate step, we estimate the total in-person days per week for staff, children, and volunteers. We replicate the in-person days per week for staff and children using the estimates reported in Table 3, but we reduce the estimate for children by 14% to account for children younger than age 2 that are not subject to the requirement. To estimate the in-person days per week for volunteers, we assume they are evenly distributed across center by operating status, such that 390,426 are associated with fully in-person centers, and 495,0975 are associated with centers in hybrid operating status. For purposes of this calculation, we assume that volunteers associated with in-person centers will volunteer in person an average of once per week, and that volunteers at centers in hybrid operating status will volunteer in person an average of once every other week. We expect that the 175,476 combined volunteers associated with closed or virtual/remote centers will not volunteer in-person. These assumptions and data indicate that Head Start volunteers will average 637,975 in-person days per week.

We assume that each staff, child, and volunteer will use one mask per day, and adopt an estimate of the cost per surgical mask of $0.14.[137] We anticipate that staff, children, and volunteers will combine for a total of 3,693,426 masks per week, with the total weekly cost of these masks of $517,080. We anticipate that a substantial portion of these individuals would wear masks when in-person at Head Start programs without this requirement, and adopt an estimate of 25% for the share of these costs that are attributable to the interim final rule. Finally, we calculate that the masking requirement will be effective for the entire time horizon of this analysis. Table 19 reports the costs of masking that are attributable to the interim final rule.

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[136] *https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html*

[137] *https://www.regulations.gov/document/OSHA-2020-0004-1033*, Table VI.B.14.

Table 19. Costs of Masking Attributable to the Interim Final Rule

Cost Element	Estimate
In-Person Days per Week, Staff	820,769
In-Person Days per Week, Children	2,598,467
In Person Days per Week, Children (2+)	2.234,682
In Person Days per Week, Volunteers	637,975
Masks per Person per Day	1
Total Masks per Week	3,693,426
Cost per Mask	$0.14
Total Cost of Masks per Week	$517,080
Attributable Share	25%
Weekly Attributable Costs	$129,270
Weeks Effective	13
Total Masking Costs	$1,680,509

Cost of Testing

We also identified a cost of testing Head Start staff and volunteers that receive an exemption from the vaccine requirement. Across all scenarios, we anticipate that 5% of Head Start Staff will receive an exemption, so 13,650 staff will be unvaccinated under the interim final rule. We further assume that 5% of Head Start volunteers, or about 53,050, will also receive an exemption. We assume that only staff and volunteers associated with Head Start centers that are fully in-person or in hybrid status will be tested. We assume that Head Start staff and volunteers will be tested weekly, and that this requirement will be effective for about 4 weeks of the time horizon of the analysis, from January 31, to March 1, 2022. This effective period is shorter than for the masking provision, which is effective immediately. We calculate that about 230,627 tests will be performed, and adopt an estimate of $10 per test. Table 20 presents these estimates and the total cost estimate of about $2.3 million. For the purpose of this analysis, we assume that the costs of testing are borne by the Head Start centers.

Table 20. Cost of Testing Unvaccinated Staff

Cost Element	Estimate
Exempted Staff	13,650
Exempted Volunteers	53,050
Total Exemptions	66,700
Share of Exemptions at In-Person/Hybrid Centers	83%
Head Start Staff and Volunteers Requiring Testing	55,669
Tests Per Week	1
Weeks Effective	4
Total Tests	230,627
Cost Per Test	$10
Total Cost of Testing	$2,306,273

Recordkeeping Costs

We anticipate that the interim final rule will result in recordkeeping activities. The Paperwork Reduction Act analysis estimates the total burden of 6,670 hours. To monetize this impact, we apply an estimate of the hourly wage of Education and Childcare Administrators, Preschool and Daycare, for individuals working in the Child Day Care Services industry. According to the U.S. Bureau of Labor Statistics, the hourly mean wage for these individuals is $24.78 per hour.[138] We adjust this hourly rate to account for benefits and other indirect costs by multiplying by two, for a fully loaded hourly wage rate of $49.56. Multiplying the fully loaded wage rate by the number of hours results in a total cost of $330,565.20.

Total Costs

We identify several sources of costs that are attributable to the interim final rule. Table 21 reports the monetized costs related to staff vacancies, costs of vaccination, costs of masking, costs of testing, and costs of recordkeeping. These estimates cover the Head Start staff vaccination coverage scenarios, and do not differ by discount rate. All estimates cover the same time horizon and are reported in 2020 dollars.

[138] *https://www.bls.gov/oes/current/oes119031.htm*. Wage rage for job code 11–9031.

Table 21. Monetized Costs Attributable to the Interim Final Rule

Value of Impact	Low	Primary	High
Staff Vacancies	$44,961,638	$22,480,819	$0
Training	$26,462,078	$13,231,039	$0
Vaccination	$7,558,658	$9,426,831	$11,295,005
Masking	$1,680,509	$1,680,509	$1,680,509
Testing	$2,306,273	$2,306,273	$2,306,273
Recordkeeping	$330,565	$330,565	$330,565
Total Monetized Costs	$83,299,721	$49,456,037	$15,612,352

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We consider it probable that the substantial reduction in COVID–19 cases per day among Head Start staff will result in fewer center closures due to COVID–19. We do not estimate the reduction in closures anticipated due to the interim final rule; however, we presented a calculation of how we would value the benefit of reopening on a per-center basis. For comparison, we also estimate the additional cost of masking, and additional cost of testing exempted staff and volunteers for centers that reopen.

If 1% of total Head Start centers reopen as a result of the interim final rule, this would result in 207 centers reopening. For the purposes of this cost analysis, we calculate the number of masks required under for a center operating fully in-person. This would result in 2,730 staff, 8,643 children, 10,610 volunteers wearing masks at in-person Head Start settings. They would require 67,474 masks on a weekly basis, 16,869 of which we attribute to the interim final rule. The total cost of these additional masks would be $2,362 per week. For testing, the same number of centers reopening would result in 667 additional exempted staff and volunteers requiring testing every week, which corresponds to $6,670 in testing costs per week. These costs sum to $9,031 per week. To continue the comparison, if 1% of closed centers reopen, we would monetize the benefits in time saved for parents and caregivers at $5.3 million per week. This comparison only includes impacts we are able to monetize, and does not account for changes in COVID–19 risks associated with reopening. As discussed elsewhere, these risks will be reduced as a result of the vaccination and masking requirements.

G. Net Benefits

We have analyzed the major impacts of the interim final rule under several scenarios of incremental vaccine-uptake among Head Start staff that are unvaccinated in the baseline scenario of no new regulatory action. In previous sections, we have indicated that the benefits are higher and that the costs are lower under the high vaccine coverage scenario than the low vaccine coverage scenario. In this section, we demonstrate the magnitudes. Table 22 presents the total costs, benefits, and net benefits that are attributable to the interim final rule under a 3% discount rate. Table 23 presents these same estimates using a 7% discount rate. Both sets of estimates cover the same time horizon.

Table 22. Net Benefits, 3% Discount Rate, 2020 dollars

Total Impacts	Low	Primary	High
Benefits	$195,986,161	$242,185,591	$288,384,996
Costs	$83,299,721	$49,456,037	$15,612,352
Net Benefits	$112,686,440	$192,729,554	$272,772,644

Table 23. Net Benefits, 7% Discount Rate, 2020 dollars

Total Impacts	Low	Primary	High
Benefits	$200,294,622	$247,964,991	$295,635,335
Costs	$83,299,721	$49,456,037	$15,612,352
Net Benefits	$116,994,900	$198,508,954	$280,022,983

An analytic issue not addressed in the assessment underlying these results is the question of how to interpret individuals' hesitation or unwillingness, in the absence of regulation, to accept an intervention that achieves extensive health protection for themselves, with little or no out-of-pocket cost, and ever-lessening time or inconvenience cost; a simplistic revealed-preference monetization of the rule's effect would be that it yields minimal or negative benefits for such staff members, even the ones for whom it prevents or reduces severity of COVID–19 infection. Given the dynamic nature of the pandemic—including scientific innovations and other human responses—it may be that long-run equilibrium for COVID–19 vaccines has not been reached, in which case the above use of VSL-related estimates for staff-member risk valuation may be appropriate at this time. On the other hand, other valuation approaches may also be worth exploring.

Toward that end, we use Herzog and Schlottmann (1990) to estimate a cap on how much the benefits of an employment-based health or safety regulation could exceed its costs.[139] Under this model, benefits accrue partially to workers in the form of health and longevity improvements (not of lost wage premiums) and partially to employers in the form of wage reductions, and the sum of worker and employer portions equals the monetized value of health and longevity improvements. Herzog and Schlottmann find that the wage reduction portion of total benefits is somewhere between 42.9% (=$4.29/$10.01) and 74.3% (=$3.67/$4.94). Put another way, the total benefits of a rule should be no more than 1.3 (=$4.94/$3.67) to 2.3 (=$10.01/$4.29) times the regulatory costs incurred by employers; otherwise, the wage reductions experienced by those employers would make it profit-maximizing (or surplus-maximizing, for non-profit entities) for them to mandate vaccination or perform the other risk-abatement activities without a regulation forcing them to do so.

The first several rows of Table 24 show upper bounds on staff benefits estimated by applying the Herzog and Schlottmann ratios to the estimated costs of the IFR (assuming for simplicity, as elsewhere in this analysis, that employers incur the costs).[140] Unlike in Tables 22 and 23, and the analysis that feeds into them, the quantified staff benefits in Table 24 are not necessarily limited to individuals who are newly vaccinated. Another, even more fundamental difference, is that Table 24 demonstrates an approach in which low costs are correlated with low staff benefits and high costs with high staff benefits.

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[139] Herzog, Henry W. and Alan M. Schlottmann. "*Valuing Risk in the Workplace: Market Price, Willingness to Pay, and the Optimal Provision of Safety*," *The Review of Economics and Statistics 72(3): August 1990. pp. 463–470.*

[140] *Herzog and Schlottmann use an old data set (1965–1970) and focus on work settings quite different from child care centers. We request comment on whether more recent or better-tailored inputs are available.*

Table 24. Net Benefits Upper Bounds, Alternative Approach, 2020 dollars

Total Impacts *	Low	Middle	High
Costs	$15,612,352	$49,456,037	$83,299,721
Upper Bound Staff Benefits, Using 1.3 Ratio	$21,014,991	$66,570,251	$112,125,510
Upper Bound Staff Benefits, Using 2.3 Ratio	$36,428,821	$115,397,419	$194,366,016
Upper Bound Total Benefits, Using 1.3 Ratio	$157,426,995	$200,820,072	$244,213,149
Upper Bound Total Benefits, Using 2.3 Ratio	$172,840,824	$249,647,240	$326,453,655
Upper Bound Net Benefits, Using 1.3 Ratio	$141,814,643	$151,364,036	$160,913,428
Upper Bound Net Benefits, Using 2.3 Ratio	$157,228,473	$200,191,203	$243,153,934

* Non-staff benefits per Table 15.

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H. Distributional Effects

Executive Order 13985 on *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* includes consideration of agency policies and actions that create or exacerbate barriers to full and equal participation by all eligible individuals. As noted previously, a large share of children served by Head Start programs are from culturally and linguistically diverse families. And the majority of Head Start children are also from families experiencing poverty. In FY 2019, OHS administrative data indicate that 37% of Head Start children were Hispanic or Latino and the remaining 63% were of non-Hispanic or Latino origin. Further, 44% were White, 30% were Black or African American, 10% were biracial or multi-racial, 4% were American Indian or Alaska Native, and 2% were Asian.[141] As is evident with these data, the indirect beneficiaries of this IFR—the children and families served by Head Start programs—are disproportionately from diverse racial and ethnic groups, as well as from low-income families, and they will benefit greatly from reduced exposure to COVID–19 from teachers who are newly vaccinated.

I. Uncertainty and Sensitivity Analysis

In the main analysis, we report the value of COVID–19 mortality risk reductions using the central HHS estimate of the VSL of $11.5 million, and value of morbidity risk reductions using estimates of the VSC that are derived from the central VSL. As a sensitivity analysis, we recalculate these benefits using the low and high estimates of the VSL, which range from $5.3 million to $17.5 million. Table 25 reports the value of these risk reductions using the full range of VSL estimates.

[141] Source: Head Start Program Information Report; the remaining 10% of children were reported as "Other or Unspecified."

Table 25. Value of COVID-19 Risk Reductions Using Range of VSL Estimates, 3% Discount Rate

Risk Reduction	VSL or VSC Estimate			Value of Risk Reduction ($ millions)		
	Low	Central	High	Low	Central	High
Mortality Reductions	$5,367,303	$11,501,365	$17,507,633	$99.6	$213.4	$324.9
Morbidity Reductions						
Mild Cases	$2,728	$5,846	$8,900	$3.2	$6.9	$10.5
Severe Cases	$6,115	$13,104	$19,947	$0.8	$1.6	$2.5
Critical Cases	$846,720	$1,814,400	$2,761,920	$6.9	$14.8	$22.6
Total Value of Risk Reductions				$110.5	$236.8	$360.5

In our main analysis, we assume that the vaccination, masking, and other requirements will be in effect for the entire time horizon of the analysis. We also considered a scenario that these requirements will end at an earlier point in time. Specifically, we evaluated a scenario that the requirements would be repealed through subsequent rulemaking or expire on January 16, 2022, which corresponds to the last day of the most recent renewal of the COVID–19 public health emergency.[142] For this scenario, we assume that Head Start staff are surprised on January 16, 2022 by the announcement, and that unvaccinated staff discontinue efforts to get fully vaccinated. This results in a lower vaccine coverage rate of between 84.9% and 91.5%, compared to a vaccine coverage rate of between 86.6% and 95.0% under the scenario of the requirement in effect through at least January 31, 2022. This would result in smaller reductions in mortality and morbidity risks, and smaller reductions in absenteeism. It would also eliminate the costs from staff vacancies and training attributable to the interim final rule, substantially reduce the costs of masking and testing; and reduce the total costs of vaccinations.

J. Analysis of Regulatory Alternatives to the Rule

We evaluated several regulatory alternatives to the interim final rule. First, we assessed the impact of not including volunteers in the scope of the vaccine requirement of the interim final rule. Under this regulatory alternative, the reductions in mortality and morbidity for volunteers induced to get fully vaccinated outlined in Tables 12 and 13 would not occur. We also anticipate a reduction in costs attributable to the rule related to the costs related to vaccination described in in Table 18. Table 26 reports the net benefits of this policy alternative, using a 3% discount rate. Compared to our analysis of the interim final rule, this option would result in lower net benefits under the vaccine coverage scenarios that we analyzed.

Table 26. Net Benefits of Policy Alternative, 3% Discount Rate, 2020 dollars

Total Impacts	Low	Primary	High
Benefits	$69,232,095	$115,431,524	$161,630,929
Costs	$78,731,453	$44,887,768	$11,044,084
Net Benefits	-$9,499,358	$70,543,756	$150,586,846

We also considered two alternatives to the masking requirement. One alternative includes eliminating the masking requirement entirely. This policy alternative would reduce the cost estimates of the interim final rule by $1.7 million in line with the calculations presented in Table 19. A second alternative would limit the masking requirement to unvaccinated individuals. Under this policy alternative, the weekly masks needed for Head Start staff and volunteers would be reduced significantly, in line with the vaccine coverage rates. When the vaccination requirement takes effect, only the 5% of Head Start staff and volunteers who receive an exemption would be expected to wear a mask. This reduces the weekly masks for Staff and volunteers

[142] *https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-15Oct21.aspx.*

attributable to the rule by about 95%. This policy alternative would also result in small reduction in the number of masks needed for children. About 1% of Head Start children are age 5 years and older, and some of these children may get vaccinated in response to CDC's "recommendation that children 5 to 11 years old be vaccinated against COVID–19 with the Pfizer-BioNTech pediatric vaccine." [143] We estimate that the cost of masking under this policy alternative would be about $1.0 million, which is about $0.6 million lower than the masking requirement under the interim final rule.

While we do not include a monetized benefit for the masking requirement, we anticipate that it will reduce transmission of SARS–COV–2 at in-person Head Start settings from individuals covered by the requirement. This impact includes a reduction in transmission from children to Head Start teachers, staff, and other children. The reductions in transmission attributable to the interim final rule will result in additional, unquantified reductions in mortality and morbidity risks to Head Start children and families, and to the general public. Compared to the analysis of the interim final rule, the two masking policy alternatives would result in fewer averted COVID–19 cases, hospitalizations, and deaths.

Finally, we considered a policy alternative of linking the vaccination, masking, and other requirements of the interim final rule to the COVID–19 public health emergency. Evaluating this policy alternative requires an additional assumption about the duration of the public health emergency. In the Uncertainty and Sensitivity Analysis, we explore a scenario in which the requirements would be repealed through subsequent rulemaking or expire on January 16, 2022, which corresponds to the last day of the most recent renewal of the COVID–19 public health emergency. That sensitivity analysis represents one possible outcome for this policy alternative. The main analysis, which assumes that the requirements will remain in effect through the time horizon of this analysis, represents another possible outcome for this policy alternative.

III. Final Small Entity Analysis

We have examined the economic implications of this interim final rule as required by the Regulatory Flexibility Act. This analysis, as well as other sections in this Regulatory Impact Analysis, serves as the Initial Regulatory Flexibility Analysis, as required under the Regulatory Flexibility Act.

A. Description and Number of Affected Small Entities

The U.S. Small Business Administration (SBA) maintains a Table of Small Business Size Standards Matched to North American Industry Classification System Codes (NAICS).[144] We replicate the SBA's description of this table:

This table lists small business size standards matched to industries described in the North American Industry Classification System (NAICS), as modified by the Office of Management and Budget, effective January 1, 2017. The latest NAICS codes are referred to as NAICS 2017.

The size standards are for the most part expressed in either millions of dollars (those preceded by "$") or number of employees (those without the "$"). A size standard is the largest that a concern can be and still qualify as a small business for Federal Government programs. For the most part, size standards are the average annual receipts or the average employment of a firm.

This interim final rule will impact small entities in NAICS category 624410, Child Day Care Services, which has a size standard of $8.0 million dollars. We assume that all 20,717 Head Start centers are below this threshold and are considered small entities.

B. Description of the Impacts of the Rule on Small Entities

We identify three categories of costs of the interim final rule that could impact small entities. Specifically, we expect that small entities will need to train Head Start staff to replace those who resign, and monetize these costs at about $13.2 million. For the purposes of this calculation, we assume that Head Start centers will purchase masks sufficient to cover every in-person staff, child, and volunteer, at a cost of about $1.7 million. We also assume that Head Start centers will incur the costs of testing for staff, at a cost of about $2.3 million. Finally, we attribute the costs of recordkeeping to small entities, at a cost of about $0.3 million. These combine for a total cost to small entities of $17.5 million. Dividing by the 20,717 Head Start centers, these costs are about $847 per small entity. As an alternative calculation, we estimate these costs are $864 per small entity, excluding closed Head Start centers.

Table 27. Costs Per Small Entity

Impact	Costs to Small Entities	Cost Per Small Entity
Training	$13,231,039	$638.66
Masking	$1,680,509	$81.12
Testing	$2,306,273	$111.32
Recordkeeping	$330,565	$15.96
Total	$17,548,386	$847.05

The Department considers a rule to have a significant impact on a substantial number of small entities if it has at least a 3% impact on revenue on at least 5% of small entities. Therefore, we perform a threshold analysis to determine whether these costs are likely to result in a significant impact on a substantial number of small entities. For $847 to exceed the impact threshold, a small entity would need to have revenue below $28,235 over the time horizon of the analysis, or annual revenue of less than about $113,000.

The Administration for Children and Families awards about $10 billion in grants to Head Start programs, including Early Head

[143] *https://www.cdc.gov/media/releases/2021/s1102-PediatricCOVID-19Vaccine.html.*

[144] U.S. Small Business Administration (2019). "Table of Size Standards." August 19, 2019. *https://www.sba.gov/document/support-table-size-standards.*

Start-Child Care Partnerships.[145] Across 20,717 centers, this averages to $466,192, which is well above the $113,000 threshold. Thus, we conclude that the interim final rule is not likely to result in a significant impact on a substantial number of small entities.

List of Subjects in 45 CFR Part 1302

COVID–19, Education of disadvantaged, Grant programs—social programs, Head Start, Health care, Mask use, Monitoring, Safety, Vaccination.

JooYeun Chang,

Principal Deputy Assistant Secretary for Children and Families.

Approved:

Xavier Becerra,

Secretary.

For the reasons discussed in the preamble, we amend 45 CFR part 1302 as follows:

PART 1302—PROGRAM OPERATIONS

■ 1. The authority citation for part 1302 continues to read as:

Authority: 42 U.S.C. 9801 *et seq.*

■ 2. In § 1302.47, revise paragraphs (b)(5)(iv) and (v) and add paragraph (b)(5)(vi) to read as follows:

§ 1302.47 Safety practices.

* * * * *

(b) * * *

(5) * * *

(iv) Only releasing children to an authorized adult;

(v) All standards of conduct described in § 1302.90(c); and

(vi) Masking, using masks recommended by CDC, for all individuals 2 years of age or older when there are two or more individuals on a vehicle owned, leased, or arranged by the Head Start program; indoors in a setting when Head Start services are provided; and for those not fully vaccinated, outdoors in crowded settings or during activities that involve sustained close contact with other people, except:

(A) Children or adults when they are either eating or drinking;

(B) Children when they are napping;

(C) When a person cannot wear a mask, or cannot safely wear a mask, because of a disability as defined by the Americans with Disabilities Act; or

(D) When a child's health care provider advises an alternative face covering to accommodate the child's special health care needs.

* * * * *

■ 3. In § 1302.93, add paragraphs (a)(1) and (2) to read as follows:

Subpart I—Human Resources Management

§ 1302.93 Staff health and wellness.

(a) * * *

(1) All staff, and those contractors whose activities involve contact with or providing direct services to children and families, must be fully vaccinated for COVID–19, other than those employees:

(i) For whom a vaccine is medically contraindicated;

(ii) For whom medical necessity requires a delay in vaccination; or

(iii) Who are legally entitled to an accommodation with regard to the COVID–19 vaccination requirements based on an applicable Federal law.

(2) Those granted an accommodation outlined in paragraph (a)(1) of this section must undergo SARS–COV–2 testing for current infection at least weekly with those who have negative test results to remain in the classroom or working directly with children. Those with positive test results must be immediately excluded from the facility, so they are away from children and staff until they are determined to no longer be infectious.

* * * * *

■ 4. In § 1302.94, revise paragraph (a) to read as follows:

§ 1302.94 Volunteers.

(a) A program must ensure volunteers have been screened for appropriate communicable diseases in accordance with state, tribal or local laws. In the absence of state, tribal, or local law, the Health Services Advisory Committee must be consulted regarding the need for such screenings.

(1) All volunteers in classrooms or working directly with children other than their own must be fully vaccinated for COVID–19, other than those volunteers:

(i) For whom a vaccine is medically contraindicated;

(ii) For whom medical necessity requires a delay in vaccination; or

(iii) Who are legally entitled to an accommodation with regard to the COVID–19 vaccination requirements based on an applicable Federal law.

(2) Those granted an accommodation outlined in paragraph (a)(1) of this section must undergo SARS-CoV–2 testing for current infection at least weekly with those who have negative test results to remain in the classroom or work directly with children. Those with positive test results must be immediately excluded from the facility, so they are away from children and staff until they are determined to no longer be infectious.

* * * * *

[FR Doc. 2021–25869 Filed 11–29–21; 8:45 am]

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[145] *https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/hs-program-fact-sheet-2019.pdf.*

EXHIBIT 2

TAGGS Grants By Location Metro Nonmetro Export						
Year	**Recipient Name**	**Recipient Address**	**Recipient City**	**County**	**Award Action Type**	**Award Sum**
2021	ALABAMA-COUSHATTA TRIBE OF TEXAS, THE	571 STATE PARK RD 56	LIVINGSTON	POLK	NEW	$30,097
2021	ALABAMA-COUSHATTA TRIBE OF TEXAS, THE	571 STATE PARK RD 56	LIVINGSTON	POLK	NON-COMPETING CONTINUATION	$412,007
2021	ALABAMA-COUSHATTA TRIBE OF TEXAS, THE	571 STATE PARK RD 56	LIVINGSTON	POLK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$119,650
2021	Kickapoo Traditional Tribe Of Texas	2212 Rosita Valley Rd	Eagle Pass	MAVERICK	NON-COMPETING CONTINUATION	$251,572
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$950,514
2021	Parent/child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$2,530,243
2021	Kickapoo Traditional Tribe Of Texas	2212 Rosita Valley Rd	Eagle Pass	MAVERICK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$251,571
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	University of Texas Rio Grande Valley, The	1201 West University Dr	Edinburg	HIDALGO	NON-COMPETING CONTINUATION	$7,727,166
2021	TEXAS TECH UNIVERSITY SYSTEM	2500 BROADWAY	LUBBOCK	LUBBOCK	NON-COMPETING CONTINUATION	$604,724
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,701,093
2021	Region XVI Education Service Center	5800 Bell St	Amarillo	RANDALL	NEW	$530,609
2021	PORT ARTHUR INDEPENDENT SCHOOL DISTRICT	4801 9TH AVE	PORT ARTHUR	JEFFERSON	NEW	$100,223
2021	DENTON INDEPENDENT SCHOOL DISTRICT	1307 N Locust St	Denton	DENTON	NEW	$58,087
2021	University of Texas Rio Grande Valley, The	1201 West University Dr	Edinburg	HIDALGO	NEW	$111,961
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$6,261,401

TAGGS Grants By Location Metro Nonmetro Export						
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NON-COMPETING CONTINUATION	$3,246,898
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NON-COMPETING CONTINUATION	$3,628,446
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$951,099
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	NON-COMPETING CONTINUATION	$548,219
2021	REGION XIX EDUCATION SERVICE CENTER	6611 BOEING DR	EL PASO	EL PASO	NON-COMPETING CONTINUATION	$43,017,731
2021	TRI-COUNTY COMMUNITY ACTION, INC.	214 NACOGDOCHES ST	CENTER	SHELBY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	ECONOMIC OPPORTUNITIES ADVANCEMENT CORPORATION OF PLANNING REGION XI	500 FRANKLIN AVE	WACO	MCLENNAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$98,864
2021	CHILD INC.	818 E 53RD ST	AUSTIN	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$188,343
2021	GULF COAST COMMUNITY SERVICES ASSOCIATION, INC.	9320 Kirby Dr	Houston	HARRIS	NON-COMPETING CONTINUATION	$19,197,707
2021	GULF COAST COMMUNITY SERVICES ASSOCIATION, INC.	9320 Kirby Dr	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	COLLEGE STATION INDEPENDENT SCHOOL DISTRICT	1812 WELSH	COLLEGE STATION	BRAZOS	NON-COMPETING CONTINUATION	$2,298,654
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	SOUTH SAN ANTONIO INDEPENDENT SCHOOL DISTRICT	1450 GILLETTE BLVD	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$30,549
2021	ASCENSION DEPAUL SERVICES	7607 Somerset Rd	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$15,319

TAGGS Grants By Location Metro Nonmetro Export						
2021	ABILENE INDEPENDENT SCHOOL DISTRICT	241 PINE ST	ABILENE	TAYLOR	NON-COMPETING CONTINUATION	$5,271,886
2021	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST	KILGORE	GREGG	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$457,458
2021	WEST TEXAS OPPORTUNITIES, INCORPORATED	603 N 4TH	LAMESA	DAWSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,399,597
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	NON-COMPETING CONTINUATION	$3,077,100
2021	University Of Texas Health Science Center At Houston, The	7000 Fannin St	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	KERRVILLE INDEPENDENT SCHOOL DISTRICT	1009 BARNETT ST	KERRVILLE	KERR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	NEW	$907,091
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	NON-COMPETING CONTINUATION	$981,333
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	NON-COMPETING CONTINUATION	$4,792,502
2021	Family Service Association Of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$22,888
2021	AVANCE - HOUSTON, INC.	4281 DACOMA ST	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$51,111
2021	Central Texas Opportunities, Inc.	114 Needham St	Coleman	COLEMAN	NEW	$121,592
2021	SAN ANTONIO, CITY OF	111 Soledad St Ste 500	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$4,025,026
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	NEW	$350,328
2021	GREENVILLE INDEPENDENT SCHOOL DISTRICT	2504 CARVER ST	GREENVILLE	HUNT	NEW	$48,456
2021	COLLEGE STATION INDEPENDENT SCHOOL DISTRICT	1812 WELSH	COLLEGE STATION	BRAZOS	NEW	$87,582

TAGGS Grants By Location Metro Nonmetro Export						
2021	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST	KILGORE	GREGG	NEW	$678,685
2021	KERRVILLE INDEPENDENT SCHOOL DISTRICT	1009 BARNETT ST	KERRVILLE	KERR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$104,096
2021	PARIS INDEPENDENT SCHOOL DISTRICT	1920 CLARKSVILLE ST	PARIS	LAMAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$248,872
2021	ABILENE INDEPENDENT SCHOOL DISTRICT	241 PINE ST	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$623,377
2021	MOUNT PLEASANT INDEPENDENT SCHOOL DISTRICT	1602 W Ferguson Rd	Mount Pleasant	TITUS	NEW	$100,825
2021	Bonham Independent School District	1005 Chestnut St	Bonham	FANNIN	NEW	$41,835
2021	PLANO INDEPENDENT SCHOOL DISTRICT	2700 W 15TH ST	PLANO	COLLIN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$174,689
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$5,006,218
2021	KIDS ARE FIRST, INC.	2208 N 1ST ST	CARRIZO SPRINGS	DIMMIT	NEW	$3,450,409
2021	COMMUNITY COUNCIL OF SOUTH CENTRAL TEXAS, INC.	801 N HIGHWAY 123 BYP	SEGUIN	GUADALUPE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	AVANCE - Houston, Inc.	4281 Dacoma St	Houston	HARRIS	NON-COMPETING CONTINUATION	$10,771,401
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$39,166
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	PLANO INDEPENDENT SCHOOL DISTRICT	2700 W 15TH ST	PLANO	COLLIN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$14,047

TAGGS Grants By Location Metro Nonmetro Export						
2021	Lumin Education	924 Wayne St	Dallas	DALLAS	NON-COMPETING CONTINUATION	$931,290
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	NON-COMPETING CONTINUATION	$33,551,283
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	MOUNT PLEASANT INDEPENDENT SCHOOL DISTRICT	1602 W Ferguson Rd	Mount Pleasant	TITUS	NON-COMPETING CONTINUATION	$3,044,616
2021	GULF COAST COMMUNITY SERVICES ASSOCIATION, INC.	9320 Kirby Dr	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$231,471
2021	COLLEGE STATION INDEPENDENT SCHOOL DISTRICT	1812 WELSH	COLLEGE STATION	BRAZOS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$267,608
2021	Central Texas Opportunities, Inc.	114 Needham St	Coleman	COLEMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$1,989,759
2021	SAN ANTONIO, CITY OF	111 SOLEDAD ST STE 500	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$12,820,917
2021	Family Service Association of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$4,295,167
2021	Family Service Association Of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$103,647
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	NON-COMPETING CONTINUATION	$2,879,782
2021	NUECES COUNTY COMMUNITY ACTION AGENCY	101 SOUTH PADRE ISLAND DR	CORPUS CHRISTI	NUECES	NON-COMPETING CONTINUATION	$12,667,944
2021	TEXARKANA SPECIAL EDUCATION CENTER, INC.	6101 N STATE LINE AVE	TEXARKANA	BOWIE	NON-COMPETING CONTINUATION	$976,825
2021	KAUFMAN INDEPENDENT SCHOOL DISTRICT	1000 S HOUSTON ST	KAUFMAN	KAUFMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$709

TAGGS Grants By Location Metro Nonmetro Export						
2021	WEBB, COUNTY OF	1308 SAN AGUSTIN AVE	LAREDO	WEBB	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$43,451
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Family Service Association of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$1,917,659
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Central Texas 4c, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	NEW	$295,551
2021	Hill Country Community Action Association, Inc.	2905 W Wallace	San Saba	SAN SABA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$870,539
2021	Texas City Independent School District	1700 9th Ave N	Texas City	GALVESTON	NEW	$46,349
2021	REGION 9 ED SERVICE CENTER	301 LOOP 11	WICHITA FALLS	WICHITA	NEW	$189,611
2021	BRAZORIA COUNTY HEAD START EARLY LEARNING SCHOOLS, INC.	651 W Miller St.	ANGLETON	BRAZORIA	NEW	$61,699
2021	Lumin Education	924 Wayne St	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$167,510
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	NEW	$446,939
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,575,791
2021	Austin Independent School District (Inc)	4000 S IH 35 Frontage Rd	Austin	TRAVIS	NEW	$61,398
2021	Community Action, Inc. Of Central Texas	215 REIMER AVE STE 130	SAN MARCOS	HAYS	NEW	$160,417
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	NEW	$8,615,877

TAGGS Grants By Location Metro Nonmetro Export						
2021	Community Council Of South Central Texas, Inc.	801N. State Hwy 123 Bypass	SEGUIN	GUADALUPE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$93,271
2021	COMMUNITY SERVICES OF N E TEXAS INC	304 E Houston St	Linden	CASS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,072,911
2021	REGION 9 ED SERVICE CENTER	301 LOOP 11	WICHITA FALLS	WICHITA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,336,679
2021	CHILD INC.	818 E 53RD ST	AUSTIN	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	NON-COMPETING CONTINUATION	$1,755,817
2021	PARENT/CHILD INCORPORATED OF SAN ANTONIO AND BEXAR	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$47,612
2021	SOUTH SAN ANTONIO INDEPENDENT SCHOOL DISTRICT	5622 RAY ELLISON BLVD	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,266,060
2021	Texas City Independent School District	1700 9th Ave N	Texas City	GALVESTON	NON-COMPETING CONTINUATION	$665,040
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	PARIS INDEPENDENT SCHOOL DISTRICT	1920 CLARKSVILLE ST	PARIS	LAMAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,807,336

TAGGS Grants By Location Metro Nonmetro Export						
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$73,073
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$17,906
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	NEW	$409,619
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	NEW	$256,426
2021	TEXARKANA SPECIAL EDUCATION CENTER, INC.	6101 N STATE LINE AVE	TEXARKANA	BOWIE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$86,148
2021	WEST ORANGE-COVE CONSOLIDATED INDEPENDENT SCHOOL	801 CORDREY ST	ORANGE	ORANGE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$285,964
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$580,303
2021	CONCHO VALLEY COUNCIL OF GOVERNMENTS	2801 W LOOP 306 STE A	SAN ANGELO	TOM GREEN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$676,023
2021	REGION XIX EDUCATION SERVICE CENTER	6611 BOEING DR	EL PASO	EL PASO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$5,234,688
2021	Williamson Burnet County Opportunities	604 High Tech Dr	Georgetown	WILLIAMSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$820,799
2021	Hidalgo County Headstart Program Inc	1901 W STATE HIGHWAY 107	MCALLEN	HIDALGO	NEW	$1,110,576
2021	Brazos Valley Community Action Programs	3991 E 29th St	Bryan	BRAZOS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$638,931
2021	TEXAS TECH UNIVERSITY SYSTEM	2500 BROADWAY	LUBBOCK	LUBBOCK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$114,864

TAGGS Grants By Location Metro Nonmetro Export						
2021	TEXAS TECH UNIVERSITY SYSTEM	2500 BROADWAY	LUBBOCK	LUBBOCK	NEW	$28,893
2021	Hill Country Community Action Association, Inc.	2905 W Wallace	San Saba	SAN SABA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,266,266
2021	DETROIT HEAD START	3rd St SE	DETROIT	RED RIVER	NEW	$536,613
2021	Lubbock Independent School District	1628 19th St	Lubbock	LUBBOCK	NON-COMPETING CONTINUATION	$3,946,570
2021	Williamson Burnet County Opportunities	604 High Tech Dr	Georgetown	WILLIAMSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$4,166,109
2021	Central Texas 4c, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$1,738,763
2021	Central Texas 4c, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$45,443
2021	Lumin Education	924 Wayne St	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$953,535
2021	San Felipe Del Rio Consolidated Independent School District	315 Griner St	Del Rio	VAL VERDE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	BRAZORIA COUNTY HEAD START EARLY LEARNING SCHOOLS, INC.	651 W Miller St.	ANGLETON	BRAZORIA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$27,528
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$37,809
2021	MOUNT PLEASANT INDEPENDENT SCHOOL DISTRICT	1602 W Ferguson Rd	Mount Pleasant	TITUS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Central Texas Opportunities, Inc.	114 Needham St	Coleman	COLEMAN	NON-COMPETING CONTINUATION	$4,605,095
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,997,853

TAGGS Grants By Location Metro Nonmetro Export						
2021	KIDS ARE FIRST, INC.	2208 N 1ST ST	CARRIZO SPRINGS	DIMMIT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	North Texas Parent And Child Development, Inc.	500 Flood St	Wichita Falls	WICHITA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	NEW	$787,034
2021	BRAZORIA COUNTY HEAD START EARLY LEARNING SCHOOLS, INC.	651 W Miller St.	ANGLETON	BRAZORIA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$245,283
2021	Pecos County Community Action Agency	101 N Jackson St	Fort Stockton	PECOS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$139,991
2021	ECONOMIC OPPORTUNITIES ADVANCEMENT CORPORATION OF PLANNING REGION XI	500 FRANKLIN AVE	WACO	MCLENNAN	NEW	$269,969
2021	Terrell Independent School District	700 N Catherine St	Terrell	KAUFMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$178,279
2021	Terrell Independent School District	700 N Catherine St	Terrell	KAUFMAN	NEW	$44,844
2021	REGION XIX EDUCATION SERVICE CENTER	6611 BOEING DR	EL PASO	EL PASO	NEW	$1,316,740
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$81,615
2021	Jumpstart Enrichment For Tomorrow's Students, Incorporated	4301 Avenue U	Snyder	SCURRY	NEW	$37,320
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$6,802,829
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$249,248
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	NON-COMPETING CONTINUATION	$929,124

TAGGS Grants By Location Metro Nonmetro Export						
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	NON-COMPETING CONTINUATION	$6,113,791
2021	REGION XIX EDUCATION SERVICE CENTER	6611 BOEING DR	EL PASO	EL PASO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$519,110
2021	Tri-County Community Action, Inc.	214 Nacogdoches St	Center	SHELBY	NON-COMPETING CONTINUATION	$6,024,306
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Parent/child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$1,973,207
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,037,771
2021	SAN ANTONIO, CITY OF	111 SOLEDAD ST STE 500	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$12,518,841
2021	Community Action, Inc. Of Central Texas	215 REIMER AVE STE 130	SAN MARCOS	HAYS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,400,464
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$99,847
2021	Hidalgo County Headstart Program Inc	1901 W STATE HIGHWAY 107	MCALLEN	HIDALGO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	DETROIT HEAD START	3rd St SE	DETROIT	RED RIVER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$22,001
2021	Family Service Association of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	NEW	$2,985,990
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$521,674

TAGGS Grants By Location Metro Nonmetro Export						
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,776,803
2021	EDUCATION SERVICE CENTER REGION 10	400 E SPRING VALLEY RD	RICHARDSON	DALLAS	NEW	$337,085
2021	PARIS INDEPENDENT SCHOOL DISTRICT	1920 CLARKSVILLE ST	PARIS	LAMAR	NEW	$62,602
2021	GALENA PARK INDEPENDENT SCHOOL DISTRICT	14705 WOODFOREST BLVD	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$76,576
2021	DENTON INDEPENDENT SCHOOL DISTRICT	1307 N LOCUST ST	DENTON	DENTON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$230,925
2021	WEBB, COUNTY OF	1308 SAN AGUSTIN AVE	LAREDO	WEBB	NEW	$409,920
2021	Ascension DePaul Services	7607 Somerset Rd	San Antonio	BEXAR	NEW	$29,796
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	NEW	$196,834
2021	Sulphur Springs Independent School District	631 Connally St	Sulphur Springs	HOPKINS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$214,174
2021	Bonham Independent School District	1005 Chestnut St	Bonham	FANNIN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$166,314
2021	NUECES COUNTY COMMUNITY ACTION AGENCY	101 SOUTH PADRE ISLAND DR	CORPUS CHRISTI	NUECES	NEW	$278,396
2021	Jumpstart Enrichment For Tomorrow's Students, Incorporated	4301 Avenue U	Snyder	SCURRY	NEW	$1,386,913
2021	NEIGHBORS IN NEED OF SERVICES, INC., (NINOS)	22887 State Highway 345	Rio Hondo	CAMERON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	NON-COMPETING CONTINUATION	$3,595,049
2021	Tyler Independent School District	1319 Earl Campbell Pkwy	Tyler	SMITH	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NON-COMPETING CONTINUATION	$3,144,787

TAGGS Grants By Location Metro Nonmetro Export						
2021	CONCHO VALLEY COUNCIL OF GOVERNMENTS	2801 W LOOP 306 STE A	SAN ANGELO	TOM GREEN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Parent/child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,110,757
2021	Family Service Association of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$4,295,167
2021	ABILENE INDEPENDENT SCHOOL DISTRICT	241 PINE ST	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$63,237
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$135,619
2021	Kickapoo Traditional Tribe Of Texas	2212 Rosita Valley Rd	Eagle Pass	MAVERICK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$40,681
2021	SER-JOBS FOR PROGRESS NATIONAL, INC.	100 EAST ROYAL LANE STE 130	IRVING	DALLAS	NON-COMPETING CONTINUATION	$1,405,668
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,345,017
2021	Hill Country Community Action Association, Inc.	2905 W Wallace	San Saba	SAN SABA	NEW	$162,222
2021	Lumin Education	924 Wayne St	Dallas	DALLAS	NEW	$42,136
2021	EDUCATION SERVICE CENTER REGION 10	400 E SPRING VALLEY RD	RICHARDSON	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,340,080
2021	PORT ARTHUR INDEPENDENT SCHOOL DISTRICT	4801 9TH AVE	PORT ARTHUR	JEFFERSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$398,435
2021	BAKERRIPLEY	450 HARRISBURG BLVD STE 20	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,494,977
2021	Williamson Burnet County Opportunities	604 High Tech Dr	Georgetown	WILLIAMSON	NEW	$206,465

TAGGS Grants By Location Metro Nonmetro Export						
2021	Hidalgo County Headstart Program Inc	1901 W STATE HIGHWAY 107	MCALLEN	HIDALGO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$4,415,085
2021	LUTHERAN SOCIAL SERVICES OF THE SOUTH, INC.	8305 CROSS PARK DR	AUSTIN	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,214,722
2021	SER-JOBS FOR PROGRESS NATIONAL, INC.	100 EAST ROYAL LANE STE 130	IRVING	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$86,148
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	NEW	$2,606,492
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 SOUTH ST	NACOGDOCHES	NACOGDOCHES	NEW	$2,786,998
2021	Community Council of South Central Texas, Inc.	801N. State Hwy 123 Bypass	SEGUIN	GUADALUPE	NON-COMPETING CONTINUATION	$1,295,685
2021	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST	KILGORE	GREGG	NON-COMPETING CONTINUATION	$16,253,413
2021	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST	KILGORE	GREGG	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$43,243
2021	Tyler Independent School District	1319 Earl Campbell Pkwy	Tyler	SMITH	NON-COMPETING CONTINUATION	$1,559,259
2021	Terrell Independent School District	700 N Catherine St	Terrell	KAUFMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	GALENA PARK INDEPENDENT SCHOOL DISTRICT	14705 WOODFOREST BLVD	HOUSTON	HARRIS	NON-COMPETING CONTINUATION	$900,007
2021	San Felipe Del Rio Consolidated Independent School District	315 Griner St	Del Rio	VAL VERDE	NON-COMPETING CONTINUATION	$2,527,857
2021	Tri-County Community Action, Inc.	214 Nacogdoches St	Center	SHELBY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0

TAGGS Grants By Location Metro Nonmetro Export						
2021	PARENT/CHILD INCORPORATED OF SAN ANTONIO AND BEXAR	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$50,927
2021	Parent/child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$2,110,758
2021	TYLER INDEPENDENT SCHOOL DISTRICT	1319 EARL CAMPBELL PKWY	TYLER	SMITH	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$87,161
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	NEW	$7,928,580
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	NON-COMPETING CONTINUATION	$2,910,398
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Avance - Houston, Inc.	4281 Dacoma St	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	North Texas Parent And Child Development, Inc.	500 Flood St	Wichita Falls	WICHITA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$208,704
2021	South San Antonio Independent School District	1450 Gillette Blvd	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$344,592
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,214,996
2021	Pecos County Community Action Agency	101 N Jackson St	Fort Stockton	PECOS	NEW	$35,213
2021	GREENVILLE INDEPENDENT SCHOOL DISTRICT	2504 CARVER ST	GREENVILLE	HUNT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$192,637
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	NEW	$386,143
2021	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST	KILGORE	GREGG	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,698,108
2021	AVANCE - Houston, Inc.	4281 Dacoma St	Houston	HARRIS	NEW	$599,531
2021	PARENT/CHILD INCORPORATED OF SAN ANTONIO AND BEXAR	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,474,088

TAGGS Grants By Location Metro Nonmetro Export						
2021	TYLER INDEPENDENT SCHOOL DISTRICT	1319 EARL CAMPBELL PKWY	TYLER	SMITH	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$239,300
2021	BEAUMONT INDEPENDENT SCHOOL DISTRICT	3395 HARRISON AVE	BEAUMONT	JEFFERSON	NEW	$153,494
2021	WEBB, COUNTY OF	1308 SAN AGUSTIN AVE	LAREDO	WEBB	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,629,633
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NEW	$557,094
2021	Lubbock Independent School District	1628 19th St	Lubbock	LUBBOCK	NEW	$162,523
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	NEW	$4,888,619
2021	Williamson Burnet County Opportunities	604 High Tech Dr	Georgetown	WILLIAMSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	NON-COMPETING CONTINUATION	$20,701,385
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	KERRVILLE INDEPENDENT SCHOOL DISTRICT	1009 BARNETT ST	KERRVILLE	KERR	NON-COMPETING CONTINUATION	$814,544
2021	PLANO INDEPENDENT SCHOOL DISTRICT	2700 W 15TH ST	PLANO	COLLIN	NON-COMPETING CONTINUATION	$1,169,138
2021	Central Texas 4C, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$4,687,480
2021	COMMUNITY SERVICES OF N E TEXAS INC	304 E HOUSTON ST	LINDEN	CASS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$50,022
2021	REGION XIX EDUCATION SERVICE CENTER	6611 BOEING DR	EL PASO	EL PASO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	DENTON INDEPENDENT SCHOOL DISTRICT	1307 N LOCUST ST	DENTON	DENTON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$17,754

TAGGS Grants By Location Metro Nonmetro Export						
2021	Bakerripley	4450 Harrisburg Blvd Ste 200	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$272,970
2021	Bonham Independent School District	1005 Chestnut St	Bonham	FANNIN	NON-COMPETING CONTINUATION	$1,094,206
2021	Ascension Depaul Services	7607 Somerset Rd	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$634,548
2021	NUECES COUNTY COMMUNITY ACTION AGENCY	101 SOUTH PADRE ISLAND DR	CORPUS CHRISTI	NUECES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$5,708,028
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	NON-COMPETING CONTINUATION	$11,259,773
2021	Hidalgo County Headstart Program Inc	1901 W STATE HIGHWAY 107	MCALLEN	HIDALGO	NON-COMPETING CONTINUATION	$14,620,859
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$3,692
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$81,615
2021	WEBB, COUNTY OF	1308 SAN AGUSTIN AVE	LAREDO	WEBB	NON-COMPETING CONTINUATION	$864,237
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$131,890
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$478,335
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	NON-COMPETING CONTINUATION	$1,315,085
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	NON-COMPETING CONTINUATION	$1,661,059
2021	North Texas Parent and Child Development, Inc.	500 Flood St	Wichita Falls	WICHITA	NEW	$28,893
2021	COMMUNITY SERVICES OF N E TEXAS INC	304 E HOUSTON ST	LINDEN	CASS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$575,517

TAGGS Grants By Location Metro Nonmetro Export						
2021	CHILD INC.	818 E 53RD ST	AUSTIN	TRAVIS	NEW	$449,648
2021	GULF COAST COMMUNITY SERVICES ASSOCIATION, INC.	9320 Kirby Dr	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,294,887
2021	HITCHCOCK INDEPENDENT SCHOOL DISTRICT	7801 Neville Ave Bldg B	Hitchcock	GALVESTON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$263,230
2021	HITCHCOCK INDEPENDENT SCHOOL DISTRICT	7801 Neville Ave Bldg B	Hitchcock	GALVESTON	NEW	$66,213
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$845,785
2021	SER-JOBS FOR PROGRESS NATIONAL, INC.	100 EAST ROYAL LANE STE 130	IRVING	DALLAS	NEW	$21,670
2021	Central Texas 4c, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$655,682
2021	ALABAMA-COUSHATTA TRIBE OF TEXAS, THE	571 STATE PARK RD 56	LIVINGSTON	POLK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$421,884
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	SAN ANTONIO, CITY OF	111 SOLEDAD ST STE 500	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$3,017,836
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$18,453
2021	PLANO INDEPENDENT SCHOOL DISTRICT	2700 W 15TH ST	PLANO	COLLIN	NEW	$43,941
2021	Cooper Independent School District	440 SW 3rd St	Cooper	DELTA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$64,611
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NEW	$3,613,699
2021	Bakerripley	4450 Harrisburg Blvd Ste 200	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$117,350
2021	BakerRipley	4450 Harrisburg Blvd Ste 200	Houston	HARRIS	NEW	$9,764,391

TAGGS Grants By Location Metro Nonmetro Export						
2021	Lubbock Independent School District	1628 19th St	Lubbock	LUBBOCK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$47,584
2021	Williamson Burnet County Opportunities	604 High Tech Dr	Georgetown	WILLIAMSON	NON-COMPETING CONTINUATION	$4,068,419
2021	GREATER OPPORTUNITIES OF THE PERMIAN BASIN INC	206 W 5TH ST	ODESSA	ECTOR	NON-COMPETING CONTINUATION	$7,219,543
2021	SAN ANTONIO, CITY OF	111 SOLEDAD ST STE 500	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$1,058,948
2021	Central Texas 4c, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,082,160
2021	COMMUNITY SERVICES OF N E TEXAS INC	304 E Houston St	Linden	CASS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	WEBB, COUNTY OF	1308 SAN AGUSTIN AVE	LAREDO	WEBB	NON-COMPETING CONTINUATION	$11,215,902
2021	Sulphur Springs Independent School District	631 Connally St	Sulphur Springs	HOPKINS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$17,348
2021	Sulphur Springs Independent School District	631 Connally St	Sulphur Springs	HOPKINS	NON-COMPETING CONTINUATION	$1,442,101
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$105,620
2021	MOUNT PLEASANT INDEPENDENT SCHOOL DISTRICT	1602 W Ferguson Rd	Mount Pleasant	TITUS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$36,524
2021	Austin Independent School District (Inc)	4000 S IH 35 Frontage Rd	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$19,977
2021	ECONOMIC OPPORTUNITIES ADVANCEMENT CORPORATION OF PLANNING REGION XI	500 FRANKLIN AVE	WACO	MCLENNAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	CONCHO VALLEY COUNCIL OF GOVERNMENTS	2801 W LOOP 306 STE A	SAN ANGELO	TOM GREEN	NON-COMPETING CONTINUATION	$6,448,244
2021	Bonham Independent School District	1005 Chestnut St	Bonham	FANNIN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$13,139

TAGGS Grants By Location Metro Nonmetro Export						
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,224,851
2021	Parent/child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,973,206
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,122,655
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	NON-COMPETING CONTINUATION	$1,096,256
2021	NUECES COUNTY COMMUNITY ACTION AGENCY	101 SOUTH PADRE ISLAND DR	CORPUS CHRISTI	NUECES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	PARIS INDEPENDENT SCHOOL DISTRICT	1920 CLARKSVILLE ST	PARIS	LAMAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$19,248
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,404,932
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$597,589
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	NON-COMPETING CONTINUATION	$2,839,309
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$30,200
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	NON-COMPETING CONTINUATION	$1,502,332
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,601,400

TAGGS Grants By Location Metro Nonmetro Export						
2021	Region XVI Education Service Center	5800 Bell St	Amarillo	RANDALL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,109,430
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	NEW	$241,077
2021	COMMUNITY COUNCIL OF SOUTH CENTRAL TEXAS, INC.	801 N HIGHWAY 123 BYP	SEGUIN	GUADALUPE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$314,680
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	NEW	$229,941
2021	Brazos Valley Community Action Programs	3991 E 29th St	Bryan	BRAZOS	NEW	$160,718
2021	North Texas Parent and Child Development, Inc.	500 Flood St	Wichita Falls	WICHITA	NEW	$541,247
2021	Hill Country Community Action Association, Inc.	2905 W Wallace	San Saba	SAN SABA	NEW	$3,189,411
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Community Council of South Central Texas, Inc.	801 N Highway 123 Byp	Seguin	GUADALUPE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,295,684
2021	COMMUNITY COUNCIL OF SOUTH CENTRAL TEXAS, INC.	801 N HIGHWAY 123 BYP	SEGUIN	GUADALUPE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$31,238
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$7,749,039
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	NON-COMPETING CONTINUATION	$3,777,581
2021	Central Texas 4C, Inc	504 N 5th St	Temple	BELL	NON-COMPETING CONTINUATION	$1,209,959
2021	Brazos Valley Community Action Programs	3991 E 29th St	Bryan	BRAZOS	NON-COMPETING CONTINUATION	$2,503,776
2021	Tri-County Community Action, Inc.	214 Nacogdoches St	Center	SHELBY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$72,354
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	NON-COMPETING CONTINUATION	$8,781,694
2021	Central Texas Opportunities, Inc.	114 Needham St	Coleman	COLEMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0

TAGGS Grants By Location Metro Nonmetro Export						
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	NON-COMPETING CONTINUATION	$2,392,414
2021	Hidalgo County Headstart Program Inc	1901 W STATE HIGHWAY 107	MCALLEN	HIDALGO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$14,973,672
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	NEW	$1,700,645
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	NON-COMPETING CONTINUATION	$1,548,295
2021	WEST TEXAS OPPORTUNITIES, INCORPORATED	603 N 4TH	LAMESA	DAWSON	NEW	$125,504
2021	Family Service Association of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	NEW	$338,892
2021	Tri-County Community Action, Inc.	214 Nacogdoches St	Center	SHELBY	NEW	$188,407
2021	COLLEGE STATION INDEPENDENT SCHOOL DISTRICT	1812 WELSH	COLLEGE STATION	BRAZOS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$348,182
2021	ECONOMIC OPPORTUNITIES ADVANCEMENT CORPORATION OF PLANNING REGION XI	500 FRANKLIN AVE	WACO	MCLENNAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,073,261
2021	Tyler Independent School District	1319 Earl Campbell Pkwy	Tyler	SMITH	NEW	$60,194
2021	GULF COAST COMMUNITY SERVICES ASSOCIATION, INC.	9320 Kirby Dr	Houston	HARRIS	NEW	$577,259
2021	SAN FELIPE DEL RIO CONSOLIDATED INDEPENDENT SCHOOL DISTRICT	315 GRINER ST	DEL RIO	VAL VERDE	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$413,989
2021	COUNTY OF SWISHER	130 N ARMSTRONG AVE	TULIA	SWISHER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$112,471

TAGGS Grants By Location Metro Nonmetro Export						
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,172,844
2021	Cooper Independent School District	440 SW 3rd St	Cooper	DELTA	NEW	$16,252
2021	COUNTY OF SWISHER	130 N ARMSTRONG AVE	TULIA	SWISHER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$385,318
2021	DETROIT HEAD START	3rd St SE	DETROIT	RED RIVER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$549,499
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,142,136
2021	Region XVI Education Service Center	5800 Bell St	Amarillo	RANDALL	NON-COMPETING CONTINUATION	$14,062,580
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 SOUTH ST	NACOGDOCHES	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$22,411
2021	AVANCE - HOUSTON, INC.	4281 DACOMA ST	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$259,394
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	SULPHUR SPRINGS INDEPENDENT SCHOOL DISTRICT	631 CONNALLY ST	SULPHUR SPRINGS	HOPKINS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	BakerRipley	4450 Harrisburg Blvd Ste 200	Houston	HARRIS	NON-COMPETING CONTINUATION	$11,329,762
2021	Pecos County Community Action Agency	101 N Jackson St	Fort Stockton	PECOS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$11,085
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Community Action, Inc. Of Central Texas	215 REIMER AVE STE 130	SAN MARCOS	HAYS	NON-COMPETING CONTINUATION	$3,320,685

TAGGS Grants By Location Metro Nonmetro Export						
2021	Community Action, Inc. Of Central Texas	215 REIMER AVE STE 130	SAN MARCOS	HAYS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	REGION VII EDUCATION SERVICE CENTER	1909 N LONGVIEW ST	KILGORE	GREGG	NON-COMPETING CONTINUATION	$457,459
2021	Hill Country Community Action Association, Inc.	2905 W Wallace	San Saba	SAN SABA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$225,625
2021	University Of Texas Health Science Center At Houston, The	7000 Fannin St	Houston	HARRIS	NEW	$250,000
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	NEW	$1,216,333
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	NEW	$2,896,900
2021	AVANCE - Houston, Inc.	4281 Dacoma St	Houston	HARRIS	NON-COMPETING CONTINUATION	$1,755,796
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	NON-COMPETING CONTINUATION	$1,952,682
2021	CHILD INC.	818 E 53RD ST	AUSTIN	TRAVIS	NON-COMPETING CONTINUATION	$769,778
2021	WEST TEXAS OPPORTUNITIES, INCORPORATED	603 N 4TH	LAMESA	DAWSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$498,941
2021	Family Service Association of San Antonio, Inc.	702 San Pedro Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,509,983
2021	DETROIT HEAD START	3rd St SE	DETROIT	RED RIVER	NEW	$39,728
2021	REGION 9 ED SERVICE CENTER	301 LOOP 11	WICHITA FALLS	WICHITA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$753,795
2021	NEIGHBORS IN NEED OF SERVICES, INC., (NINOS)	22887 State Highway 345	Rio Hondo	CAMERON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,900,316
2021	Tri-County Community Action, Inc.	214 Nacogdoches St	Center	SHELBY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$749,009
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,633,223

TAGGS Grants By Location Metro Nonmetro Export						
2021	GREATER OPPORTUNITIES OF THE PERMIAN BASIN INC	206 W 5TH ST	ODESSA	ECTOR	NEW	$253,416
2021	CHILD INC.	818 E 53RD ST	AUSTIN	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,787,571
2021	KIDS ARE FIRST, INC.	2208 N 1ST ST	CARRIZO SPRINGS	DIMMIT	NEW	$211,280
2021	Sulphur Springs Independent School District	631 Connally St	Sulphur Springs	HOPKINS	NEW	$53,873
2021	COUNTY OF SWISHER	130 N ARMSTRONG AVE	TULIA	SWISHER	NEW	$28,291
2021	Jumpstart Enrichment For Tomorrow's Students, Incorporated	4301 Avenue U	Snyder	SCURRY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$16,562
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$1,251,900
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	NON-COMPETING CONTINUATION	$4,690,364
2021	SAN ANTONIO, CITY OF	111 Soledad St Ste 500	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$25,282
2021	TEXAS TECH UNIVERSITY SYSTEM	2500 BROADWAY	LUBBOCK	LUBBOCK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$9,598
2021	TERRELL INDEPENDENT SCHOOL DISTRICT	700 N CATHERINE ST	TERRELL	KAUFMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$13,486
2021	PARENT/CHILD INCORPORATED OF SAN ANTONIO AND BEXAR	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$22,710
2021	CHILD INC.	818 E 53RD ST	AUSTIN	TRAVIS	NON-COMPETING CONTINUATION	$15,638,266
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$21,077
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	BCFS EDUCATION SERVICES	1506 Bexar Crossing	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$1,436,153

TAGGS Grants By Location Metro Nonmetro Export						
2021	HITCHCOCK INDEPENDENT SCHOOL DISTRICT	7801 Neville Ave Bldg B	Hitchcock	GALVESTON	NON-COMPETING CONTINUATION	$819,272
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	NON-COMPETING CONTINUATION	$1,950,900
2021	COUNTY OF SWISHER	130 N ARMSTRONG AVE	TULIA	SWISHER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Jumpstart Enrichment For Tomorrow'S Students, Incorporated	4301 Avenue U	Snyder	SCURRY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	University Of Texas Health Science Center At Houston, The	7000 Fannin St	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$1,660
2021	AVANCE - Houston, Inc.	4281 Dacoma St	Houston	HARRIS	NON-COMPETING CONTINUATION	$4,290,560
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,707,064
2021	Rolling Plains Management Corporation	118 North 1st St	Crowell	FOARD	NEW	$131,222
2021	DETROIT HEAD START	3rd St SE	DETROIT	RED RIVER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$179,939
2021	SAN ANTONIO, CITY OF	111 SOLEDAD ST STE 500	SAN ANTONIO	BEXAR	NEW	$1,012,460
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$958,397
2021	NEIGHBORS IN NEED OF SERVICES, INC., (NINOS)	22887 State Highway 345	Rio Hondo	CAMERON	NEW	$729,549
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,535,110
2021	KERRVILLE INDEPENDENT SCHOOL DISTRICT	1009 BARNETT ST	KERRVILLE	KERR	NEW	$26,184

TAGGS Grants By Location Metro Nonmetro Export						
2021	GREATER OPPORTUNITIES OF THE PERMIAN BASIN INC	206 W 5TH ST	ODESSA	ECTOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,007,453
2021	AVANCE - HOUSTON, INC.	4281 DACOMA ST	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,383,428
2021	ABILENE INDEPENDENT SCHOOL DISTRICT	241 PINE ST	ABILENE	TAYLOR	NEW	$156,805
2021	Parent/child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	NEW	$370,794
2021	ASCENSION DEPAUL SERVICES	7607 SOMERSET RD	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$118,454
2021	University Of Texas Rio Grande Valley, The	1201 West University Dr	Edinburg	HIDALGO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$445,098
2021	Austin Independent School District (Inc)	4000 S IH 35 Frontage Rd	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$244,086
2021	Child Care Associates	3000 E Belknap St	Fort Worth	TARRANT	NEW	$546,560
2021	NUECES COUNTY COMMUNITY ACTION AGENCY	101 SOUTH PADRE ISLAND DR	CORPUS CHRISTI	NUECES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,106,763
2021	Community Action Corporation Of South Texas	204 E 1st St	Alice	JIM WELLS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$185,647
2021	COUNTY OF SWISHER	130 N ARMSTRONG AVE	TULIA	SWISHER	NEW	$376,307
2021	NEIGHBORS IN NEED OF SERVICES, INC., (NINOS)	22887 State Highway 345	Rio Hondo	CAMERON	NON-COMPETING CONTINUATION	$23,684,623
2021	Cooper Independent School District	440 SW 3rd St	Cooper	DELTA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$4,814
2021	Terrell Independent School District	700 N Catherine St	Terrell	KAUFMAN	NON-COMPETING CONTINUATION	$1,123,343
2021	COMMUNITY SERVICES OF N E TEXAS INC	304 E Houston St	Linden	CASS	NON-COMPETING CONTINUATION	$2,072,914
2021	BRAZORIA COUNTY HEAD START EARLY LEARNING SCHOOLS, INC.	651 W Miller St.	ANGLETON	BRAZORIA	NON-COMPETING CONTINUATION	$2,289,072

TAGGS Grants By Location Metro Nonmetro Export						
2021	BakerRipley	4450 Harrisburg Blvd Ste 200	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$11,329,759
2021	Austin Independent School District (Inc)	4000 S IH 35 Frontage Rd	Austin	TRAVIS	NON-COMPETING CONTINUATION	$1,658,881
2021	ECONOMIC OPPORTUNITIES ADVANCEMENT CORPORATION OF PLANNING REGION XI	500 FRANKLIN AVE	WACO	MCLENNAN	NON-COMPETING CONTINUATION	$8,210,503
2021	Pecos County Community Action Agency	101 N Jackson St	Fort Stockton	PECOS	NON-COMPETING CONTINUATION	$924,234
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	NON-COMPETING CONTINUATION	$2,215,797
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	WEST TEXAS OPPORTUNITIES, INCORPORATED	603 N 4TH	LAMESA	DAWSON	NON-COMPETING CONTINUATION	$2,343,356
2021	Central Texas 4c, Inc	504 N 5th St	Temple	BELL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$11,058
2021	REGION XIX EDUCATION SERVICE CENTER	6611 BOEING DR	EL PASO	EL PASO	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Central Texas Opportunities, Inc.	114 Needham St	Coleman	COLEMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$483,386

TAGGS Grants By Location Metro Nonmetro Export						
2021	COMMUNITY SERVICES OF N E TEXAS INC	304 E HOUSTON ST	LINDEN	CASS	NEW	$144,766
2021	BakerRipley	4450 Harrisburg Blvd Ste 200	Houston	HARRIS	NEW	$879,131
2021	Motivation, Education & Training, Inc.	22551 Gene Campbell Blvd	New Caney	MONTGOMERY	NEW	$396,376
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	NEW	$260,940
2021	TEXAS NEIGHBORHOOD SERVICES	522 PALO PINTO ST	WEATHERFORD	PARKER	NEW	$326,850
2021	KIDS ARE FIRST, INC.	2208 N 1ST ST	CARRIZO SPRINGS	DIMMIT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$3,533,440
2021	GREATER EAST TEXAS COMMUNITY ACTION PROGRAM	1716 South St	Nacogdoches	NACOGDOCHES	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$929,123
2021	AVANCE - Houston, Inc.	4281 Dacoma St	Houston	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$10,771,400
2021	SAN ANTONIO, CITY OF	111 SOLEDAD ST STE 500	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,058,947
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$16,913
2021	TEXAS TECH UNIVERSITY SYSTEM	2500 BROADWAY	LUBBOCK	LUBBOCK	NON-COMPETING CONTINUATION	$803,692
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$951,100
2021	Parent/Child Incorporated Of San Antonio And Bexar	7815 MAINLAND DR STE 101	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Childcaregroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NON-COMPETING CONTINUATION	$4,608,708
2021	Ascension Depaul Services	7607 Somerset Rd	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$634,547

TAGGS Grants By Location Metro Nonmetro Export						
2021	EDUCATION SERVICE CENTER REGION 10	400 E SPRING VALLEY RD	RICHARDSON	DALLAS	NON-COMPETING CONTINUATION	$10,250,930
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	NON-COMPETING CONTINUATION	$13,961,297
2021	GREENVILLE INDEPENDENT SCHOOL DISTRICT	2504 CARVER ST	GREENVILLE	HUNT	NON-COMPETING CONTINUATION	$1,267,574
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$2,569,089
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$146,726
2021	University Of Texas Health Science Center At Houston, The	7000 Fannin St	Houston	HARRIS	NON-COMPETING CONTINUATION	$225,000
2021	Jumpstart Enrichment For Tomorrow'S Students, Incorporated	4301 Avenue U	Snyder	SCURRY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	North Texas Parent And Child Development, Inc.	500 Flood St	Wichita Falls	WICHITA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	NON-COMPETING CONTINUATION	$1,934,355
2021	TEXARKANA SPECIAL EDUCATION CENTER, INC.	6101 N STATE LINE AVE	TEXARKANA	BOWIE	NEW	$21,670
2021	South San Antonio Independent School District	1450 Gillette Blvd	San Antonio	BEXAR	NEW	$86,679
2021	WEST ORANGE-COVE CONSOLIDATED INDEPENDENT SCHOOL	801 CORDREY ST	ORANGE	ORANGE	NEW	$71,932
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	NEW	$145,970
2021	CONCHO VALLEY COUNCIL OF GOVERNMENTS	2801 W LOOP 306 STE A	SAN ANGELO	TOM GREEN	NEW	$170,048
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	NEW	$410,823
2021	MOUNT PLEASANT INDEPENDENT SCHOOL DISTRICT	1602 W Ferguson Rd	Mount Pleasant	TITUS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$400,828
2021	Community Action, Inc. Of Central Texas	215 REIMER AVE STE 130	SAN MARCOS	HAYS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$637,735

TAGGS Grants By Location Metro Nonmetro Export						
2021	WEST ORANGE-COVE CONSOLIDATED INDEPENDENT SCHOOL	801 CORDREY ST	ORANGE	ORANGE	NON-COMPETING CONTINUATION	$1,752,651
2021	Region Xvi Education Service Center	5800 Bell St	Amarillo	RANDALL	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$168,968
2021	EDUCATION AGENCY, TEXAS	1850 STATE HWY 351	ABILENE	TAYLOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$639,002
2021	ChildCareGroup	420 West Mockingbird Ln Ste 3(	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$561,313
2021	Brazos Valley Community Action Programs	3991 E 29th St	Bryan	BRAZOS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$2,564,001
2021	BEAUMONT INDEPENDENT SCHOOL DISTRICT	3395 HARRISON AVE	BEAUMONT	JEFFERSON	NON-COMPETING CONTINUATION	$3,535,265
2021	HEAD START OF GREATER DALLAS INC	3954 GANNON LN	DALLAS	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$404,572
2021	DENTON INDEPENDENT SCHOOL DISTRICT	1307 N Locust St	Denton	DENTON	NON-COMPETING CONTINUATION	$1,476,401
2021	PARIS INDEPENDENT SCHOOL DISTRICT	1920 CLARKSVILLE ST	PARIS	LAMAR	NON-COMPETING CONTINUATION	$1,599,957
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	GREATER OPPORTUNITIES OF THE PERMIAN BASIN INC	206 W 5TH ST	ODESSA	ECTOR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$76,018
2021	TEXAS MIGRANT COUNCIL INC	5215 MCPHERSON RD	LAREDO	WEBB	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$620,335
2021	Kickapoo Traditional Tribe of Texas	2212 Rosita Valley Rd	Eagle Pass	MAVERICK	NEW	$10,233

TAGGS Grants By Location Metro Nonmetro Export						
2021	Center For Transforming Lives	512 W 4th St	Fort Worth	TARRANT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$63,274
2021	Texas City Independent School District	1700 9th Ave N	Texas City	GALVESTON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$184,261
2021	HARRIS COUNTY DEPARTMENT OF EDUCATION	6300 IRVINGTON BLVD	HOUSTON	HARRIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,517,162
2021	Community Council of South Central Texas, Inc.	801 N Highway 123 Byp	Seguin	GUADALUPE	NEW	$79,155
2021	GALENA PARK INDEPENDENT SCHOOL DISTRICT	14705 WOODFOREST BLVD	HOUSTON	HARRIS	NEW	$19,262
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$914,126
2021	San Felipe Del Rio Consolidated Independent School District	315 Griner St	Del Rio	VAL VERDE	NEW	$104,135
2021	BEAUMONT INDEPENDENT SCHOOL DISTRICT	3395 HARRISON AVE	BEAUMONT	JEFFERSON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$610,215
2021	Education Service Center Region 20	1314 Hines Ave	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,037,366
2021	KIDS ARE FIRST, INC.	2208 N 1ST ST	CARRIZO SPRINGS	DIMMIT	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$839,943
2021	Jumpstart Enrichment For Tomorrow'S Students, Incorporated	4301 Avenue U	Snyder	SCURRY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$148,366
2021	Lubbock Independent School District	1628 19th St	Lubbock	LUBBOCK	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$646,110
2021	Central Texas 4C, Inc	504 N 5th St	Temple	BELL	NEW	$164,931
2021	North Texas Parent And Child Development, Inc.	500 Flood St	Wichita Falls	WICHITA	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,320,969

TAGGS Grants By Location Metro Nonmetro Export						
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$40,266
2021	NEIGHBORS IN NEED OF SERVICES, INC., (NINOS)	22887 State Highway 345	Rio Hondo	CAMERON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$318,883
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	NON-COMPETING CONTINUATION	$1,418,844
2021	Central Texas 4C, Inc	504 N 5th St	Temple	BELL	NON-COMPETING CONTINUATION	$1,738,763
2021	Cooper Independent School District	440 SW 3rd St	Cooper	DELTA	NON-COMPETING CONTINUATION	$405,529
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$43,725
2021	AVANCE, INC.	118 N MEDINA ST	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$654,264
2021	PORT ARTHUR INDEPENDENT SCHOOL DISTRICT	4801 9TH AVE	PORT ARTHUR	JEFFERSON	NON-COMPETING CONTINUATION	$2,804,619
2021	REGION 9 ED SERVICE CENTER	301 LOOP 11	WICHITA FALLS	WICHITA	NON-COMPETING CONTINUATION	$2,281,651
2021	HEAD START OF GREATER DALLAS INC	3954 Gannon Ln	Dallas	DALLAS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	CONCHO VALLEY COUNCIL OF GOVERNMENTS	2801 W LOOP 306 STE A	SAN ANGELO	TOM GREEN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$77,623
2021	Lutheran Social Services Of The South, Inc.	8305 Cross Park Dr	Austin	TRAVIS	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$594,494
2021	Central Texas Opportunities, Inc.	114 Needham St	Coleman	COLEMAN	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$55,316
2021	SOUTH PLAINS COMMUNITY ACTION ASSOCIATION, INC.	411 AUSTIN ST	LEVELLAND	HOCKLEY	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$28,776

TAGGS Grants By Location Metro Nonmetro Export						
2021	Cen-Tex Family Services, Inc.	2402 N Main St	Bastrop	BASTROP	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	SOUTH SAN ANTONIO INDEPENDENT SCHOOL DISTRICT	5622 RAY ELLISON BLVD	SAN ANTONIO	BEXAR	NON-COMPETING CONTINUATION	$1,266,061
2021	Texas City Independent School District	1700 9th Ave N	Texas City	GALVESTON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$681,090
2021	BCFS EDUCATION SERVICES	1506 BEXAR CROSSING	SAN ANTONIO	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$1,470,797
2021	HITCHCOCK INDEPENDENT SCHOOL DISTRICT	7801 Neville Ave Bldg B	Hitchcock	GALVESTON	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$839,041
2021	AVANCE, INC.	903 Billy Mitchell Blvd Ste 100	San Antonio	BEXAR	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	$0
2021	DETROIT HEAD START	3rd St SE	DETROIT	RED RIVER	ADMINISTRATIVE SUPPLEMENT (+ OR -) (DISCRETIONARY OR BLOCK AWARDS)	-$16,233
Exported on 12 / 08 / 2021 from the HHS Tracking Accountability in Government Grants System (TAGGS), http://taggs.hhs.gov						**$842,280,184**

EXHIBIT 3

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

STATE OF TEXAS and LUBBOCK INDEPENDENT SCHOOL DISTRICT, *Plaintiff*,	§	
v.	§	**CIVIL ACTION NO. _____**
XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOOYUEN CHANG, in her official capacity as Principal Deputy Assistant Secretary; ADMINISTRATION FOR CHILDREN AND FAMILIES; KATIE HAMM, in her official capacity as Deputy Assistant Secretary for Early Childhood Development; OFFICE OF EARLY CHILDHOOD DEVELOPMENT; BERNADINE FUTRELL, in her official capacity as Director of the Office of Head Start; OFFICE OF HEAD START; and JOSEPH R. BIDEN, in his official capacity as President of the United States, *Defendants.*	§	

DECLARATION OF DR. KATHY ROLLO

My name is Dr. Kathy Rollo, and I am over the age of 18 and fully competent in all respects to make this declaration. I have personal knowledge and expertise of the matters herein stated.

1. I am the Superintendent of the Lubbock Independent School District (LISD) and have been in my current position since February of 2018. In this capacity, I oversee the management and operations of LISD, which serves approximately 26,000 students and

employs approximately 3,000 people. LISD is comprised of 29 elementary schools, 10 middle schools, and 5 high schools. 71.96 percent of LISD's students are living in poverty as defined by the State of Texas.

2. LISD is currently serving 1,265 children in Pre K 3 and 4 year old programs. This number includes 556 students who qualify for federal Head Start funding through a grant. Based on the parameters of the grant, LISD will receive actual funding for 540 of the 556 qualifying students. LISD Head Start students are served in 26 of our 29 elementary campuses in 70 classrooms. LISD Head Start staff include 70 teachers, 70 teaching assistants, 1 Lead Head Start specialist, 12 Head Start specialists, 2 Instructional coaches, 1 data specialist, 1 secretary, 1 Head Start manager, and 1 Head Start Director. LISD Head Start teachers are certified and teaching assistants hold a Child Development Associates or college certification in order to be employed in the program. The program caps enrollment at 20 students per 2 adults in the 4 year old classrooms and 17 students per 2 adults in the 3 year old classrooms. In LISD, students qualifying for Head Start funds are integrated with students who qualify for State Pre K funding and tuition-based students.

3. On Monday, November 29, 2021, LISD was notified through a Head Start webinar and subsequent written notice of an "Interim Final Rule with Comment Period" (IFR), which added two provisions to the Head Start Program Performance Standards to mitigate the spread of Covid 19 in Head Start programs. First, the IFR required universal masking for all individuals two years of age and older, with some noted exceptions, effective upon publication and beginning November 30, 2021. The requirement was stated with less than 24 hours of notice for planning and communication. The second addition requires all Head Start staff, contractors whose activities involve contact with or providing direct services to children and families, and volunteers working in classrooms or directly with children to be vaccinated for Covid 19 by January 31, 2022.

4. After our school buildings were closed in the Spring of 2020, LISD safely welcomed students back into its buildings for the 2020-2021 school year. In line with Governor Abbott's Executive Order and TEA Public Health Guidance, LISD implemented a mask mandate for all staff and for students in 4th grade and above. While younger students had the option to wear masks, LISD did not require them for multiple reasons. First and foremost, masks inhibit a young child's ability to effectively learn language and social skills. Secondly, the management of enforcing a mask mandate with young children is challenging in that young children are more apt to drop them, play with them, sneeze and cough in them. Lastly, the science we read indicated that younger children were at far less risk of contracting Covid 19 or getting extremely sick with Covid 19. Overall, LISD believed that the negative effects of wearing masks in Pre K through 3rd grades were far greater than what protection they provided. While LISD's mask mandate remained in effect for the entirety of the school year, at no time did LISD require students below the 4th grade to wear masks.
5. As we began to prepare for the 2021-2022 school year, LISD determined that our stance would be that masks are welcome, and vaccinations are encouraged. The word "welcome" with regard to masks was strategically selected because LISD wanted staff, students, and families to make the decision that best met their needs. At no point during the current school year has our Covid 19 positivity rate gone above 2%. Most of the semester it has been below 0.5%. The majority of student cases have been in our secondary schools. Of our 1,847 active cases since August 18, 2021, only 26 have been Pre K students and none have been Pre K staff.
6. LISD has encouraged vaccinations since they were first made available in January of 2021. Working very closely with the City of Lubbock Health Department, LISD has partnered in hosting vaccination clinics at the City of Lubbock Civic Center and at our campuses throughout the spring, summer, and fall of 2021. In an anonymous survey

conducted in August before school started, 84% of LISD's staff reported having received at least one vaccine dose. This high rate of staff vaccination has been achieved without a mandate. Having a mandate for a subset of employees creates inequity in staff expectations,

7. In order for children to develop the ability to read clues for language and social situations it is crucial they can see an adult or other children's faces. Masks can dampen sounds from 3-12 decibels. This can result in difficulty understanding high frequency sound differences both at the word level (fan vs van) and with basic grammatical markers (stops vs stopped) , disrupting language learning across areas such as vocabulary, phonology and syntax. Phonological acquisition is a primary predictor of later reading ability. Optimal learning for phonology occurs when children are able to both see and hear sounds. A solid phonological representation of what the sound looks like as it is produced and what it sounds like as it is spoken becomes the foundation for the orthographic representation of the sound during literacy development. This is true with typically developing learners but becomes critical for children with speech and language deficits where multimodal instruction (auditory, visual and kinesthetic) becomes an imperative teaching tool. During the Pre K years students are also learning to incorporate facial expressions and oral motor movements as additional communication clues. Masks can make it more difficult for children to assimilate all of the various unspoken communication cues used by others.

8. As a result of Covid 19, LISD experienced a decline in enrollment in its Pre K programs last year. Enrollment was 1,072 students in 2020 and 1,011 students in 2021. However, as the result of an active recruitment campaign, LISD is currently serving 1,265 students, and that recruitment continues today. Parents made the choice to send their children to Pre K knowing that masks were welcome, but not required. Many parents have stated

that they do not want their children to wear masks. If LISD were to comply with the mask requirement, we could potentially lose many of the students who are currently enrolled in the program, disrupting the progress that has been made. Pre K is an essential part of preparing children, particularly children living in poverty, for success in school and life.

9. The new IFR requirements have the potential of dramatically impacting LISD's Pre K staffing. Very few early childhood staff are currently choosing to wear masks. They understand the importance of children seeing their facial expressions and fully hearing their voices as they model language, read to them, and interact with them. The few staff members who are not vaccinated have chosen not to do so. If LISD complies with these new requirements, it has the potential for a mass exodus of Pre K staff. Staff members may choose to resign, or they may ask to be reassigned to a non Head Start position. Both of these create a lack of continuity for the students and tremendous staffing challenges for LISD in a time when the district, like districts across the country, is already having a difficult time filling vacancies and retaining employees. These mandates exacerbate the staffing issues schools are facing.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on December 10, 2021 in Lubbock, Texas.

Dr. Kathy Rollo

EXHIBIT 4

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

THE STATE OF TEXAS, et al. ***Plaintiffs*****,**	§	
v.	§	**No: _____**
JOSEPH R. BIDEN in his official capacity as President of the United States, et al., ***Defendants.***	§	

DECLARATION OF ERIC BENTLEY

My name is Eric Bentley, and I am over the age of 18 and fully competent in all respects to make this declaration. I have personal knowledge and expertise of the matters herein stated.

1. I am the Vice Chancellor and General Counsel of the Texas Tech University System ("TTUS") and have been in my current position since September of 2018. In this capacity, I oversee the legal matters for TTUS and its five component institutions: Texas Tech University ("TTU"), Texas Tech University Health Sciences Center ("TTUHSC"), Texas Tech University Health Sciences Center El Paso ("TTUHSC EP"), Angelo State University ("ASU"), and Midwestern State University ("MSU").

2. TTU operates a Center for Early Head Start Program as an initiative of the Department of Development and Family Sciences ("CEHS"). The CEHS currently has approximately 47 employees and provides services to over 70 children and families.

3. The CEHS received an email on November 12, 2021 from the U.S. Department of Health and Human Services ("DHHS") (Attached) indicating that all CEHS employees would be

required to be fully vaccinated with a COVID-19 vaccine or receive an approved exemption on or before "January 2022." This notification from DHHS indicated that any CEHS staff who does not obtain the COVID-19 vaccination by "January 2022" cannot be employed with CEHS. Based on this communication and the "January 2022" deadline to be fully vaccinated, CEHS was forced to take preparatory steps including a notification to employees on or about November 22, 2021 informing them of the DHHS vaccine requirement. In this same November 22, 2021 communication, CEHS, through the TTU Department of Human Resources, sought information from each CEHS employee as to (1) vaccination status, (2) whether the employee was seeking a religious or medical exemption, or (3) a timeline by which the employee intended to be vaccinated if the employee was not seeking a medical or religious exemption.

4. On or about Monday, November 29, 2021, CEHS became aware of the formal notice of the published DHHS performance standards to implement vaccine requirements and masking requirements. The rules published by DHHS indicated they were effective November 30, 2021. On or about this same day, CEHS received a PowerPoint presentation from DHHS with additional information on the implementation of the rules, including the effective date for the masking requirement of November 30, 2021. This PowerPoint presentation indicated the date by which all employees must be fully vaccinated was January 31, 2021.

5. The COVID-19 vaccine exemption requests submitted by CEHS employees to the TTU Department of Human Resources are currently pending review and approval in consultation with the TTUS Office of General Counsel.

6. All the facts and information contained within this declaration are within my personal knowledge and are true and correct.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 10th day, December 2021, in Lubbock, Texas.

ERIC BENTLEY

From: Bentley, Eric
To: Bentley, Eric
Subject: FW: Vaccine mandate TTU Center for Early Head Start
Date: Friday, December 10, 2021 10:28:24 AM

From: Cobbs, Jennifer (ACF) <Jennifer.Cobbs@acf.hhs.gov>
Sent: Friday, November 12, 2021 6:36 PM
To: Shine, Stephanie <Stephanie.Shine@ttu.edu>
Subject: RE: Vaccine mandate TTU Center for Early Head Start

Your welcome Stephanie,

I understand and appreciate your diligence in seeking clarification as many other programs have raised similar questions and concerns. However at this time, I must reiterate; if staff refuse to receive a COVID-19 vaccination and or If staff do not get fully vaccinated by January 2022, they can no longer be employed with the Head Start program. Staff must be fully vaccinated by January 2022 to remain employed with the Head Start program.

Exceptions may be made for appropriate religious and medical reasons. (This is based on your local policies and procedures that have been put in place by your agency)

Vaccination and mask requirements are the strongest layered mitigation strategies to protecting children, as well as their families, from staff-to-child transmission of COVID-19.

Additionally, staff who opt not to have the COVID-19 vaccine collect unemployment are generally ineligible for unemployment benefits. However, there may be some exceptions as unemployment qualification is not the same in every state. Programs should consult their state laws on this matter.

Lastly, the vaccination requirement will be reviewed during OHS monitoring aa OHS will be making adjusts to its monitoring protocol to include staff vaccinations requirements as part of a review of personnel records. I hope this helps to ensure your program develops polices that align to the federal mandate around vaccination requirement for 2022.

Please let me know if you would prefer a follow up call to discuss any additional questions you may have.

~Jennifer

From: Shine, Stephanie <Stephanie.Shine@ttu.edu>
Sent: Friday, November 12, 2021 12:12 PM
To: Cobbs, Jennifer (ACF) <Jennifer.Cobbs@acf.hhs.gov>
Subject: Re: Vaccine mandate TTU Center for Early Head Start

Thank you Jennifer, I have passed this information on.

Specifically, our university is looking at the various different regulations from other federal agencies which have already provided them and which do differ in particular ways. For example, some agencies are much more explicit about what a religious or medical waiver looks like and require a doctor's note.

Our HR team is seeking to guide us appropriately based on a legal authorization.

I don't know that they will allow us to move ahead without that authorization.

We are in a tight timeframe to terminate and hire staff given the holidays.

Thanks,

Stephanie

On Nov 12, 2021, at 11:06 AM, Cobbs, Jennifer (ACF) <Jennifer.Cobbs@acf.hhs.gov> wrote:

Good morning Stephanie.

The interim final has not been issued yet. Nor has there been a PI/IM issued. Please refer to the following ECLKC link, in which provides additional resources and information: https://eclkc.ohs.acf.hhs.gov/about-us/coronavirus/ohs-

covid-19-updates.

Please remember that ultimately the Interim Final Rule (IFR) *is what you are expected to follow once published*

Please let me know if you have additional questions. Have a wonderful weekend.

From: Shine, Stephanie <Stephanie.Shine@ttu.edu>
Sent: Thursday, November 11, 2021 3:50 PM
To: Cobbs, Jennifer (ACF) <Jennifer.Cobbs@acf.hhs.gov>
Subject: Vaccine mandate TTU Center for Early Head Start
Importance: High

Hi Jennifer,

Our university is looking for guidelines from DHHS on the vaccine mandate.
Do you know if these are forthcoming?

Thank you!

Stephanie

Stephanie Shine, PhD | Associate Professor of Practice
Associate Chair | Human Development & Family Sciences
Executive Director | Center for Early Head Start
College of Human Sciences | Texas Tech University

P: 806.834.4664 | E: stephanie.shine@ttu.edu
1301 Akron Avenue | HDFS | Office 507H | Lubbock, TX 79409-1230

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

State of Texas and Lubbock Independent School District

(b) County of Residence of First Listed Plaintiff Lubbock Co., TX
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Charles Eldred, Amy Hilton, Office of the Attorney General, Div., P. O. Box 12548, Austin, TX 78711/ 512-475-4300

DEFENDANTS

Xavier Becerra, in his official capacity as Secretary of Health & Human Services, et al.

County of Residence of First Listed Defendant Washington, D.C.
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
Administrative Procedure Act

Brief description of cause:
Promulgated rule outside statutory authority and violation of APA and Constitution

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
December 10, 2021

SIGNATURE OF ATTORNEY OF RECORD
/s/ Charles Eldred

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related cases, if any. If a related case exists, whether pending or closed, insert the docket numbers and the corresponding judge names for such cases. A case is related to this filing if the case: 1) involves some or all of the same parties and is based on the same or similar claim; 2) involves the same property, transaction, or event; 3) involves substantially similar issues of law and fact; and/or 4) involves the same estate in a bankruptcy appeal.

Date and Attorney Signature. Date and sign the civil cover sheet.