GOVERNORS PUBLIC HEALTH ALLIANCE

July 12, 2026

Submitted via www.regulations.gov

Andrew Reisig & Joel Savary
Office of Federal Financial Management
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

RE: Docket No. OMB-2026-0034, *Regulation for Federal Financial Assistance*, 91 Fed. Reg. 32198 (May 29, 2026).

Dear Mr. Reisig and Mr. Savary,

On behalf of the Governors Public Health Alliance (PHA), we appreciate the opportunity to submit comments on the Office of Management and Budget's (OMB) proposed regulation for financial assistance. As a nonpartisan coalition of 15 governors, representing approximately one-third of the American population, PHA is committed to protecting and advancing the health and wellbeing of millions of Americans across our states.[1]

If implemented, OMB's regulation would fundamentally change how the federal government awards and administers financial assistance to all grant recipients, including state and local government, hospitals, institutions of higher education, and nonprofits nationwide, introducing significant unpredictability for the state budgets, partner institutions, and communities that rely on these funds. State public health infrastructure relies on these entities, who will suffer devastating financial setbacks and uncertainty if these proposed changes are effectuated. As a result, public health across the country will deteriorate, and the individuals and families we serve will suffer.

As governors responsible for implementing public health policy and managing state healthcare systems, we have witnessed firsthand the importance of grounding public health decisions, including funding decisions, in science and stability. We therefore urge you to withdraw this proposed rule and instead ensure that: (1) long-term public health planning and research maintains its predictability; (2) public health remains grounded in science-backed evidence and produces the

[1] PHA membership includes California Governor Gavin Newsom, Colorado Governor Jared Polis, Connecticut Governor Ned Lamont, Delaware Governor Matt Meyer, Guam Governor Lou Leon Guerrero, Hawai'i Governor Josh Green, Illinois Governor JB Pritzker, Maryland Governor Wes Moore, Massachusetts Governor Maura Healey, New Jersey Governor Mikie Sherrill, New York Governor Kathy Hochul, North Carolina Governor Josh Stein, Oregon Governor Tina Kotek, Rhode Island Governor Daniel McKee, and Washington Governor Bob Ferguson.

highest quality research; and (3) data disaggregated by important demographic categories continues to be reported and monitored.

A. The proposed rule would create new authority to terminate, pause, or modify already-awarded funding, undermining the stability on state budgets, public health programs, research initiatives, and state planning efforts depend.

Public health programs, research initiatives, and state planning efforts require reliability. States build multi-year budgets around federal funding commitments; when the federal government can discontinue that funding without cause, responsible state budgeting becomes impossible. The proposed rule creates three new mechanisms through which the federal government could terminate, freeze, or otherwise place at risk funds that have already been awarded to a grantee: (1) discretionary termination for discretionary awards;[2] (2) a 90-day funding pause for discretionary awards;[3] and (3) termination based on the conduct or status of a subrecipient that seems to apply to all awards.[4] In addition, the proposed revisions to § 200.208 would significantly expand agency authority to place terms and conditions on awards by authorizing agencies to add or remove specific conditions placed on existing awards "throughout the period of performance," not only at the time of award. This expanded authority to add new terms and conditions purports to apply to all federal funding, including non-discretionary funding such as states' federal formula and block grants, contrary to congressional intent. Importantly, failure to adhere to the revised terms and conditions could serve as a mechanism for discretionary termination under § 200.340(a)(4), which is especially concerning given that recipients would need to make these mid-performance adjustments within just 15 days.

Collectively, these changes, if implemented, could allow federal funding to be interrupted even after it is awarded, creating instability for state budgets and undermining long-term public health planning, program implementation, and health workforce stability. Public health initiatives often require sustained funding commitments over multiple years to develop infrastructure, recruit and retain personnel, evaluate outcomes, and maintain continuity of services.[5] Funding instability will undermine efforts related to vaccine preparedness, infectious disease response, disease surveillance, and other core public health functions.

We are particularly concerned about the implications for public health research, especially given that the CDC's 10 Essential Public Health Services framework recognizes that improving public

[2] 2 C.F.R. § 200.340(a)(2).
[3] Proposed 2 C.F.R. § 200.340(e) at 32,259.
[4] Proposed 2 C.F.R. § 200.332 at 32,225.
[5] Dara Alpert Lieberman, *Beyond the Boom-and-Bust Cycle: The Need for a Long-Term Funding Strategy for Public Health*, Coal. for Health Funding (July 28, 2022), https://www.publichealthfunding.org/blog/beyond-the-boom-and-bust-cycle-the-need-for-a-long-term-funding-strategy-for-public-health.

health depends on ongoing evaluation, research, and continuous quality improvement.[6] Many federally funded studies, including randomized controlled trials and longitudinal population health studies, require years of continuous funding to produce reliable results. Any modifications or terminations of the research mid-cycle could undermine study integrity, participant safety, or the legitimacy of the study's outcome.[7] The proposed changes also create uncertainty for researchers considering long-term projects, particularly in fields where research outcomes may not be realized for many years or even decades. Such uncertainty could ultimately discourage investment in resource-intensive public health research initiatives,[8] wasting public dollars already committed and harming public health innovations in this country over time.[9]

For example, a clinical trial evaluating a new cancer treatment may take a few years to design and fund, three to four years to conduct, and several more years of long-term follow-up.[10] Recent findings have even suggested multiple decades of participant follow-up for optimal understanding of long-term consequences.[11] If funding for such a trial is terminated or its terms are substantially altered midway through the process for reasons unrelated to scientific merit, years of work and millions of dollars in public investment could be lost.[12] Further, midcycle termination of a clinical trial could place participating patients at risk of harm and could prevent the discovery of new lifesaving treatments.[13]

Importantly, while the proposed discretionary termination and pause authorities in §§ 200.340 and 200.341 are expressly limited to discretionary awards, proposed § 200.332 on subrecipient-based termination contains no comparable limitation. As written, the proposed subrecipient-based termination authority could potentially extend to non-discretionary funding streams, including federal formula and block grants administered by states, in direct contravention of congressional intent. This raises significant concerns for state agencies that rely on predictable funding structures to administer large-scale public health programs.

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[6] Centers for Disease Control and Prevention, 10 Essential Public Health Services (Revised 2020) https://www.cdc.gov/public-health-gateway/php/about/index.html ((last visited June 26, 2026).
[7] The Editors, The OMB and the Politicization of Science, N. Engl. J. Med. (June 15, 2026), https://doi.org/10.1056/NEJMe2608017.
[8] Max Crowley, *Public Health Needs Steady Budgets—and Federal Funding Uncertainty Can Cause Real Harms, Even if the Money Is Later Restored*, Wash. Post (Ripple) (Mar. 6, 2026), https://www.washingtonpost.com/ripple/2026/03/06/public-health-needs-steady-budgets-and-federal-funding-uncertainty-cause-real-harms-even-if-the-money-is-later-restored/.
[9] Beth Faiman, *The Impact of Federal Funding Cuts on Research, Practice, and Patient Care*, 16 J. Advanced Prac. Oncology 124 (2025).
[10] *How Long Does Each Clinical Trial Last?*, Astellas Clinical Trials, https://www.clinicaltrials.astellas.com/how-long-do-clinical-trials-take.
[11] Jack Cuzick, *The Importance of Long-Term Follow Up of Participants in Clinical Trials*, 128 Brit. J. Cancer 432 (2023).
[12] The Editors, The OMB and the Politicization of Science, N. Engl. J. Med. (June 15, 2026), https://doi.org/10.1056/NEJMe2608017.
[13] *Id.*

If implemented as written, the provision could significantly restructure state subrecipient monitoring systems by requiring states to thoroughly assess the "reputational" risk associated with subrecipients, including expanded review and monitoring of sub-recipient activities and public communications. State agencies may need to develop new compliance, monitoring, and oversight frameworks, creating substantial administrative burdens for already resource-constrained public health agencies.

In addition, community-based organizations that play a critical role in delivering public health services—particularly for underserved and hard-to-reach populations—may curtail certain activities, public communications, or programmatic initiatives out of concern that such actions could jeopardize continued funding, or in fact could lose that funding under the proposed rule's broad and vague terms. For example, a state may be uncertain whether a local nonprofit that conducts outreach to hard-to-reach communities about childhood vaccinations or preventive health screens runs afoul of the proposed rule. The result could be reduced participation by trusted community partners in and diminished effectiveness of federally funded public health programs, leaving vulnerable populations at greater risk.

B. The proposed rule would reduce the role of independent, merit-based scientific review in discretionary public health grantmaking, risking the quality and return on taxpayer-funded research.

The federal government must rely on objective, evidence-based expertise when making public health decisions that affect all states. We are concerned that this proposed rule permits funding decisions to be untethered from the rigorous peer review that has historically guided them, reducing the quality and value of the research the public pays for. Specifically, the proposed revisions to § 200.205 would give senior political appointees a substantially larger role in reviewing discretionary grant awards by requiring agency heads to "designate one or more senior appointees to conduct a pre-issuance review of all discretionary awards," which "may form the basis of a decision not to select an applicant."[14] Proposed revisions to § 200.205(c) would further require that political appointees "not ministerially ratify or routinely defer to the recommendations of others," and "must instead use their independent judgment when evaluating Federal award proposals."[15] As a result, political appointees may consider but not defer to expert judgment, reducing the role of scientific-based expertise and evidence in the federal award process.

This proposed change risks the quality of federally funded scientific research. For example, a rigorous and independent peer review of grant applications is essential to determine where money allocated to the National Institutes of Health (NIH) is directed. For decades, the NIH's merit-based

[14] Guidance for Federal Financial Assistance, 91 Fed. Reg. 32,198, 32,249 (proposed May 29, 2026) (to be codified at 2 C.F.R. § 200.205).
[15] Proposed 2 C.F.R. § 200.205(c) at 32,249.

review system has directed funding toward the most scientifically rigorous and promising research proposals.[16] As a result, NIH-funding has driven research related to 99% of newly approved medications in the U.S.[17]—helping to produce lifesaving vaccines, improved treatments for cancer and heart disease, reduced infant mortality, and expanding our understanding of how to prevent and respond to infectious disease outbreaks. These life-saving scientific advances were only possible because NIH funding decisions were grounded in scientific merit and expert evaluation.

If political appointees are directed to rely on their own "independent judgment" rather than to defer to expert, evidence-based review in grant award selection, grant proposals will risk being evaluated on considerations other than scientific merit. This could discourage investment in long-term public health research, resulting in fewer scientific breakthroughs, slower development of new treatments and prevention strategies, and reduced capacity to respond to emerging public health threats. Public health innovations and improvements function through ongoing evaluation, research, and continuous quality improvement, which largely depend on confidence that research funding will be awarded based on evidence and scientific merit rather than political considerations.[18] These proposed changes greatly undermine that confidence.

C. The proposed rule would prohibit the use of federal awards to support disparate impact analysis, creating confusion surrounding conflicts with the statutes that require states to collect and report demographic data that are critical to improving public health outcomes and to directing limited dollars efficiently.

Demographic data is essential to improving public health outcomes, as reflected in the federal statutes governing public health funding. We are deeply concerned that the new proposed § 200.218 would require agencies to "eliminate the use of disparate-impact liability in all contexts relevant to Federal awards" and bar recipients from using award funds for disparate-impact studies, litigation, or related activities unless expressly required by law.[19]

Many federally funded public health programs ***require*** states to collect, analyze, and report data on health outcomes across demographic categories such as race, ethnicity, sex, and other population characteristics. While the proposed rule appears to except programs that require the collection of such data from the prohibition, the uncertainty and confusion resulting from the sweeping prohibition and broad language could jeopardize critical public health programs.

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[16] The Editors, *The OMB and the Politicization of Science*, N. Engl. J. Med. (June 15, 2026), https://doi.org/10.1056/NEJMe2608017.
[17] E. Galkina Cleary et al., *Comparison of Research Spending on New Drug Approvals by the National Institutes of Health vs the Pharmaceutical Industry, 2010–2019*, 4 JAMA Health Forum e230511 (2023).
[18] D. Abbot et al., *In Defense of Merit in Science*, 3 J. Controversial Ideas 1 (2023), https://doi.org/10.35995/jci03010001.
[19] Proposed 2 C.F.R. § 200.218 at 32,252.

For example, the Preventive Health and Health Services ("PHHS") Block Grant, a discretionary grant awarded by the Department of Health and Human Services, which provided flexible funding to support state public health priorities ranging from $400,000 to $11 million for FY2025, expressly requires states to specify the populations that state-funded activities will serve, including "any populations in the State that have a disparate need for such activities."[20] In practice, states use demographic health data to identify communities experiencing disproportionate health burdens and direct resources where they are most needed.[21] For example, a state may use data showing elevated rates of maternal mortality among Black women, higher rates of diabetes in rural communities, or increased overdose deaths in particular regions to develop targeted interventions and evaluate whether those interventions are improving health outcomes. The proposed rule's vague language creates uncertainty as to whether these longstanding and practices are exempt as "expressly required by law."

A similar conflict arises under the Maternal and Child Health Services ("MCH") Research Program. The program, which provides approximately $818 million annually to support the health of mothers, infants, and children, is governed by statutory provisions that expressly require the identification, measurement, and monitoring of disparities in maternal and child health outcomes.[22] Specifically, 42 U.S.C. § 706 requires reporting on key health indicators "by racial and ethnic group," reflecting Congress's determination that demographic data are relevant to evaluating and improving public health outcomes. These reporting requirements—covering areas such as maternal mortality, prenatal care access, infant mortality, and low birth weight—are a part of a statutory framework that relies on race- and ethnicity-specific data for program planning, evaluation, and accountability. Because it fails to grapple with specific programs and their statutory requirements, the proposed rule is unclear as to whether such reporting requirements are intended to be exempted from the disparate impact prohibition.

These examples are illustrative, not exhaustive—there are numerous federal public health program statutes containing criteria that would conflict with the proposed § 200.218. If the proposed rule is implemented, states will be forced to navigate this prohibition on disparate impact analysis and expend immense resources determining if their programs are excepted from it.

Even in the absence of a conflict with statutes governing particular programs, the proposed rule's prohibition on disparate impact research will undermine public health. Data from demographic studies allows decisionmakers to identify communities experiencing the greatest public health challenges and to direct public health resources where they are needed most and used most

[20] 42 U.S.C. Chapter 6A, Subchapter XVII, Part A, Section 300w-4.
[21] The Pew Charitable Trusts, *State Public Health Data Reporting Policies and Practices Vary Widely* (Dec. 12, 2024), https://www.pew.org/en/research-and-analysis/reports/2024/12/state-public-health-data-reporting-policies-and-practices-vary-widely.
[22] 42 U.S.C. Chapter 7, Subchapter V.

efficiently.[23] They are crucial for states and their public health agencies to identify health problems in their communities, allocate resources properly, evaluate program interventions, and ultimately save lives.[24]

For example, if a state finds that women in a particular racial or ethnic community experience higher rates of maternal mortality or reduced access to prenatal care, it can develop strategies and direct resources designed to improve outcomes for these mothers and newborns. In the absence of reliable demographic data, states may be less able to identify these disparities, evaluate whether interventions are working, and ensure that public health resources are reaching the communities with the greatest need.[25]

The Public Health Alliance's member governors are committed to ensuring that federal public health decisions remain grounded in scientific expertise, objective evaluation, and administrative stability. States and the federal government are budget partners; when federal funding becomes unpredictable, both levels of government, and the citizens they serve, bear the cost. The proposed rule would introduce significant uncertainty into federal grantmaking, diminish the role of evidence-based decision-making, and create substantial challenges for states collecting data critical to essential public health programs. For these reasons, we urge OMB and the 42 co-signing agencies to withdraw the proposed revisions to the Uniform Guidance. We are also deeply concerned about the speed at which a major rule such as this one is being finalized, and we urge OMB to provide additional time for the public to provide meaningful comment on this rulemaking.

Sincerely,

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Managing Director
Governors Public Health Alliance

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[23] Andis Robeznieks, *Demographic Data Can Identify Health Inequities. Here's How*, Am. Med. Ass'n (June 19, 2024), https://www.ama-assn.org/public-health/health-equity/demographic-data-can-identify-health-inequities-here-s-how.

[24] McKenzie D. Campbell, Gina M. Pannell & J. Mac McCullough, *Alignment of Public Health Agency Demographics With Populations Served*, 32 J. Pub. Health Mgmt. & Prac. S76 (2026), https://doi.org/10.1097/PHH.0000000000002236.

[25] Blue Cross Blue Shield Ass'n, *Health Equity Cannot Be Achieved Without Data Equity* (Apr. 29, 2024), https://www.bcbs.com/about-us/association-news/health-equity-cannot-be-achieved-without-data-equity.