July 13, 2026

SUBMITTED ELECTRONICALLY VIA WWW.REGULATIONS.GOV

The Honorable Russell Vought
Director
Office of Management and Budget
725 17th Street NW
Washington, DC 20503

RE: Comments on OMB-2026-0034-0001 Regulation for Federal Financial Assistance [2 CFR §§200.202, 200.205, 200.206, 200.218, 200.300(b), 200.305, 200.340–200.343, 200.421, 200.432, 200.450, 200.454, 200.461, 200.467]

Dear Mr. Vought,

The undersigned represent a broad coalition of health centers, primary care associations, health center-controlled networks, public health institutions, and advocacy organizations, along with 35 public health policy deans, chairs, and scholars (in their individual capacities), and individual advocates committed to ensuring that the federal grant framework supports, rather than undermines, the delivery of care to medically underserved, vulnerable populations and the communities in which they live.

We file this comment on the Office of Management and Budget's ("OMB") May 29, 2026 proposed rule, titled "Regulation for Federal Financial Assistance" (File Code: OMB-2026-0034-0001) ("Proposed Rule"). The Proposed Rule would make dozens of significant changes to Part 200 of Title 2 of the US Code of Federal Regulations governing how the federal government awards, oversees, and manages grants, cooperative agreements, and other forms of financial assistance. We are deeply concerned that the Proposed Rule would significantly impair the ability of safety-net providers and community-based organizations to serve medically underserved communities. The Proposed Rule threatens access to and continuity of essential, community-based health care for some of the most vulnerable populations in the nation. **For these reasons, we respectfully urge the OMB to withdraw the Proposed Rule.** We elaborate on these concerns below, with particular attention to the provisions of the Proposed Rule that would most directly threaten the stability and accessibility of health care services for vulnerable and underserved communities.

Although many examples herein draw primarily from the health center context, the harms are not unique to health centers. The same dynamics apply across the broad range of community-based organizations, state and local governments, educational institutions, and other entities that depend on multi-year discretionary federal awards to deliver services to underserved populations. OMB should treat the health center examples as illustrative of a systemic problem, not as an isolated concern.

Liberty Health Alliance ("LHA") is a national, not-for-profit organization that focuses on the impact of public health policy reforms on medically underserved, vulnerable populations and the communities in which they live. LHA has a special interest in programs and policies that can promote access to comprehensive primary health care across the full age spectrum.

The Jacobs Institute of Women's Health is based at the Milken Institute School of Public Health at George Washington University and publishes the peer-reviewed journal Women's Health Issues. Our mission is to identify and study aspects of healthcare and public health, including legal and policy issues, which affect women's health at different life stages; to foster awareness of and facilitate dialogue around issues that affect women's health; and to promote interdisciplinary research, coordination, and information dissemination. We support policies that promote women's access to comprehensive health care and other conditions that enable them to live healthy lives.

The National Center for Medical-Legal Partnership (NCMLP), based at the Milken Institute School of Public Health at the George Washington University, leads education, research, and technical assistance efforts to help health organizations throughout the United States incorporate legal aid services as a standard component of their response to health-related social needs. Medical-legal partnerships integrate the unique expertise of lawyers into health care settings to help health care teams providers and systems address the root causes of poor health outcomes and costs NCMLP aims to shift healthcare practices and policies to proactively consider legal needs and solutions as part of a comprehensive approach to patient care. We achieve this by leading efforts to transform policy and practice, convene stakeholders, build evidence, and attract investment to support medical-legal partnerships.

The American Public Health Association (APHA) is a non-partisan, non-profit organization that champions the health of all people and all communities; strengthens the profession of public health; shares the latest research and information; promotes best practices; and advocates for public health issues and policies grounded in scientific research. APHA represents more than 23,000 individual members and has 52 state and regional affiliates. APHA's membership also includes organizational members, including groups interested in health, state and local health departments, and health-related businesses. APHA is the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

Defend Public Health (DPH) is an unincorporated nonprofit association with a membership of over 12,000 members in more than 40 states, including physicians, nurses, legal scholars, current and former public health officials, and academic scientists working in biomedical and clinical research, epidemiology, and other areas of public health.

The Massachusetts League of Community Health Centers (Mass League) is the Primary Care Association in Massachusetts and offers support for the Commonwealth's 50 community health centers organizations. Among many initiatives, the Mass League's training, technical assistance, and advocacy help health centers best serve their patients and adapt to the ever-changing landscape of health care.

California Primary Care Association (CPCA) represents more than 2,300 not-for-profit Community Health Centers (CHCs) and clinics that provide comprehensive, high-quality healthcare and strengthen communities throughout California. As the statewide leader and recognized voice for California's community health centers and their patients, CPCA is committed to advancing policies that support equitable access to care. CPCA works to help CHCs fulfill their mission of overcoming barriers to healthcare, including poverty, lack of health insurance, language, disability, homelessness, geographic isolation, and other social and economic challenges. Through this work, CPCA advocates for policies that ensure all Californians have access to the care they need, regardless of their circumstances.

Oregon Primary Care Association (OPCA) is the unified voice of Oregon's Federally Qualified Health Centers (FQHCs), including Look-Alikes, who deliver integrated medical, dental, and behavioral health services to 500,000+ Oregonians at 330+ locations statewide. OPCA fosters collaboration with CHC professionals across the state through technical assistance, operational support, and capacity building. Additionally, OPCA collects and analyzes statewide data from health centers to identify trends in population health and then uses that information as a basis to support policy and regulatory improvements which reduce barriers to care and support health centers

The Mid-Atlantic Association of Community Health Centers (MACHC) represents Maryland and Delaware's 19 federally qualified health centers—nonprofit primary care providers with a collective mission to treat all patients, regardless of ability to pay.

The individual signatories are distinguished deans, chairs, and scholars at the nation's leading academic institutions and research universities. They are experts in the fields of health law, public health, health care policy and research, and national health reform. They include individuals with deep expertise in the regulatory, compliance, and administrative frameworks that govern the relationship between federal agencies and the recipients of federal financial assistance. The individual signatories join this comment in their individual capacities and not as representatives of their respective institutions. The complete list of individual signatories is included at the end of this letter.

I. Expansion of Federal Award Suspension and Termination Authority

[§§200.340–343] OMB proposes to expand and codify agency authority to discretionarily withhold or terminate active federal awards without advance notice, the opportunity to

object, or access to an impartial hearing or appeal. The Proposed Rule also introduces a new temporary suspension authority at section 200.340(e), authorizing agencies and pass-through entities to issue written stop-work orders for up to 90 days based solely on their own determination that suspension serves their interest, with no requirement of noncompliance or other cause.

The Proposed Rule's expansion of termination authority is unlawful. OMB already possesses the authority to terminate awards for noncompliance, and agencies retain the ability to define program priorities through the award process itself, including through terms and conditions, funding opportunity announcements, and scope of work requirements. [1] These existing mechanisms reflect the boundaries Congress established, and grounds for termination that fall outside those boundaries are unauthorized, as Congress has not delegated authority to OMB to expand the bases for termination beyond noncompliance and award-specific conditions.[2] Termination of congressionally appropriated funds on grounds not authorized by statute is also inconsistent with the Impoundment Control Act of 1974, which establishes the exclusive procedures by which the Executive may withhold funds Congress has directed to be spent. That the Proposed Rule proceeds through notice-and-comment rulemaking does not cure the defect; the Administrative Procedure Act process cannot authorize what Congress has not.

The Proposed Rule compounds this problem by authorizing termination whenever an agency determines that an award no longer serves program goals, agency priorities, or the national interest as they exist at the time of termination. 91 Fed. Reg. 32198 (May 29, 2026) (proposed 2 C.F.R. 200.340). This standard invites termination decisions driven by political considerations rather than programmatic ones, without advanced notice to recipients, without an opportunity to respond, and without access to an impartial hearing or appeal. An agency that terminates a grant on those grounds does not faithfully execute the law Congress enacted; it substitutes its own policy preferences for the legislative judgment that authorized and appropriated the funds.[3]

The Proposed Rule is also arbitrary and capricious within the meaning of the Administrative Procedure Act because OMB has not articulated a reasoned basis for departing from the longstanding regulatory framework that provided recipients with predictable, rule-bound termination procedures and meaningful procedural protections. An agency changing course must supply a reasoned explanation for disregarding the reliance interest its prior policy engendered, and OMB has not done so here. In addition, the longstanding

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[1] 2 C.F.R. 200.340(a)(1); 2 C.F.R. 200.340(a)(4), (b); *see also* 89 Fed. Reg. 30046, 30089 (Apr. 22, 2024) (OMB preamble explaining that section 200.340(a)(4) requires express inclusion in award-specific terms and conditions to be operative).

[2] Impoundment Control Act of 1974, 2 U.S.C. 681 et seq.

[3] U.S. Const. art. II, sec. 3 (requiring the President to "take Care that the Laws be faithfully executed"); *see also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (agency action is arbitrary and capricious if the agency "entirely failed to consider an important aspect of the problem").

termination framework has generated substantial reliance interests on the part of federal award recipients generally, and OMB's Proposed Rule fails to grapple with those reliance interests at all.[4]

Under OMB's Proposed Rule, an agency or pass-through entity may terminate a federal award if it determines that termination is in the interest of the agency, including "if a Federal award does not effectuate program goals, Federal agency priorities, or the national interest as they exist at the time of the termination." 91 Fed. Reg. 32198, 32258–32259 (May 29, 2026) (proposed 2 C.F.R. 200.340). Separately, proposed section 200.340(e) would authorize agencies and pass-through entities to issue a written stop-work order for up to 90 days upon determining that suspension is in their interest. *Id.* (proposed 2 C.F.R. 200.340). Together, these provisions give agencies broad, cause-free authority to halt or end award activity at any stage of performance based on agency priorities or national interests. This introduces an unacceptable degree of uncertainty to grantees who have invested a substantial amount of time, capital, and resources into effectuating the award. The sweeping discretionary termination and suspension authorities proposed in section 200.340 are not needed to protect the federal interest. Instead, these newly proposed authorities would remove the procedural and substantive guardrails that protect grantees from arbitrary mid-award suspension or termination. The threat of these mid-award suspensions and terminations would destabilize grantee operations and jeopardize the continuity of essential services for the most vulnerable and underserved communities.

The consequences of unchecked suspension and termination authorities would extend far beyond the loss of a single award. For safety-net providers and community-based organizations whose mission is to advance access to health care and public health, a mid-award suspension or termination could trigger a cascade of disruptions: to employees who have built careers in mission-driven service, to the communities that have nowhere else to turn, and to the financial foundations on which these organizations depend. The following sections describe the concrete harms that health centers, safety-net providers and community-based organizations and the communities they serve would face if Section 200.340 is finalized as written.

- **Employees**: A mid-award termination or suspension would devastate the community-based health care and public health workforce that health centers and safety-net providers have built to serve medically underserved populations. For clinical providers, behavioral health care, care coordinators, community health workers, and others who have built careers in mission-driven service, a mid-award

[4] 5 U.S.C. 706(2)(A); *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42-43 (1983) (agency action is arbitrary and capricious where the agency fails to provide a reasoned explanation for departing from prior policy).

termination or suspension could be devastating. Even a temporary stop-work order under proposed section 200.340(e) could force organizations to furlough or terminate staff, as most community-based organizations lack the services to sustain payroll through a 90-day suspension. These are not positions that can be held vacant while a new funding source is identified. Further, a mid-cycle termination would not give affected employees meaningful notice or transition time, and in most medically underserved communities the pipeline of qualified health center and public health professionals is not sufficient to replace a disrupted workforce without lasting damage to the care infrastructure those communities depend on. The perception that federal funding is unreliable would compound this problem. State and local public health departments already face serious difficulties recruiting and retaining qualified staff, in part because cyclical funding that expands in response to specific crises and contracts when those crises recede has produced chronic workforce shortages across the country.[5] These shortages are acute in the underserved communities that safety-net providers like health centers serve, where the National Health Service Corps is often the single most effective recruiting tool available. Clinicians who accept National Health Service Corps loan repayment or scholarship obligations in exchange for service commitments in underserved settings depend on the continued availability of qualifying practice sites. Funding instability that threatens those sites undermines the NHSC pipeline and would deter future clinicians from making that commitment in the first place.[6] Extending that instability to the broader universe of federal award recipients would deepen an already serious public health workforce crisis.

- **Communities**: Termination or suspension of federal awards would fall hardest on communities that can least afford disruption. These populations, both rural and urban, disproportionately depend on federally funded health care, public health programming, and related services precisely because market-based alternatives are absent or inaccessible.[7] Many of these communities already face compounding barriers to care, including acute primary care and behavioral health provider shortages, geographic isolation, and limited broadband access that restricts the

[5] Jonathon P. Leider et al., *The Exodus of State and Local Public Health Employees: Separations Started Before and Continued Throughout COVID-19*, 42 Health Affairs 338, 338 (2023). State and local health departments need an estimated 80,000 additional full-time employees to provide foundational public health services. GAO, Public Health Preparedness: HHS and Jurisdictions Have Taken Some Steps to Address Challenging Workforce Gaps, GAO-25-107002, at 1 (Jan. 29, 2025) (citing de Beaumont Foundation 2021 national study).

[6] NHSC loan repayment and scholarship recipients must fulfill a minimum two-year service commitment at an NHSC-approved site located in a Health Professional Shortage Area. 42 U.S.C. §§ 254l, 254l-1. Funding instability that forces NHSC-approved sites to close or suspend operations mid-obligation may prevent clinicians from fulfilling their service commitments through no fault of their own.

[7] As of March 31, 2026, over 101 million people — approximately 30 percent of the U.S. population — reside in a primary medical care Health Professional Shortage Area. HRSA, Bureau of Health Workforce, Designated Health Professional Shortage Areas Statistics, Second Quarter of Fiscal Year 2026 (as of Mar. 31, 2026), available at data.hrsa.gov.

availability of telehealth as an alternative means of reaching communities. Marginalized communities bear a disproportionate share of these challenges. In many medically underserved communities, there is no underlying health care infrastructure that federal grant funding supplements. The grant-funded safety-net provider is the only source of care. For the communities these organizations serve, losing a federal award does not mean reduced access to care; it means no access to care.[8]

- **Operations**: Community-based health care organizations depend on multi-year federal awards to build the clinical infrastructure, workforce capacity, and community trust that are essential to serving medically underserved populations effectively. These organizations structure their operations, facilities, and staffing around the expectation that federal award commitments will be honored over the full period of performance.[9] A mid-cycle termination or suspension would do more than reduce operating revenue. For organizations that have incurred debt obligations in direct reliance on the stability of their federal awards, it could trigger loan defaults, jeopardize capital assets, and permanently impair the organizational capacity needed to serve the community.

  The uncertainty created by broad discretionary termination and suspension authority would also undermine planning processes that are themselves federally encouraged and, in many cases, federally required. Health centers and other safety-net providers operate under statutory and programmatic frameworks that require them to assess community health needs, develop service delivery plans, and expand access to populations experiencing persistent health disparities. Mid-cycle termination or suspension would strain the investments already made in those processes and leave communities that were promised expanded access without the care that was being developed to serve them.[10]

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[8] In 2024, HRSA-funded health centers served more than 32.4 million patients, approximately 90 percent of whom had incomes at or below 200 percent of the federal poverty level. Health centers are located in medically underserved areas and serve as a critical source of primary care for communities who would otherwise lack access to care. HRSA, Bureau of Primary Health Care, *Impact of the Health Center Program* (Aug. 2025), available at bphc.hrsa.gov; HRSA, *HRSA-Funded Health Centers Served Over 32.4 Million Patients in 2024* (Aug. 4, 2025).

[9] Health centers depend on multi-year federal awards to build the clinical infrastructure, workforce capacity, and community trust that are essential to serving medically underserved populations effectively. These organizations structure their operations, facilities, and staffing around the expectation that federal award commitments will be honored over the full period of performance. *See* 42 U.S.C. § 254b(e)(2) (authorizing use of grant funds for acquisition of facilities and equipment and workforce training); HRSA, Health Center Program Compliance Manual ch. 3, 5, 8 (needs assessment, clinical staffing, and accessible locations and hours of operation), *available at* bphc.hrsa.gov.

[10] Section 330 of the Public Health Service Act and its implementing regulations require health centers to conduct needs assessments of their target populations and to develop and implement responsive service delivery plans as conditions of their federal award. 42 U.S.C. 254b(k)(2); 42 U.S.C. 254b(k)(3)(C); 42 C.F.R. 51c.303(k); HRSA, Health Center Program Compliance Manual, ch. 3 (current ed.), available at bphc.hrsa.gov.

Many of these organizations also rely on overlapping awards from multiple federal agencies, including HRSA, SAMHSA, CDC, and HUD, to finance services that cannot be sustained through health care delivery revenue alone. The loss of even a single award can destabilize the entire funding structure, making it effectively impossible to maintain program continuity across the board.[11] For health centers specifically, the harm extends beyond the lost award itself. Under the Proposed Rule, grantees would face a choice that no mission-driven health care organization should have to make, continue providing evidence-based care to vulnerable communities and risk termination, or scale back federally mandated services in order to reduce regulatory exposure. Either outcome is directly contrary to the statutory purposes these organizations exist to fulfill.

- **Credit and Financial Stability**:

  The proposed expansion of discretionary termination and suspension authority would also materially undermine the financial stability of safety-net health care organizations. Independent credit analysts have identified the Proposed Rule as a credit negative for entities with high dependence on competitive federal funding, concluding that it would materially weaken the reliability of multi-year discretionary funding commitments.[12] Health centers and similar community-based providers rely on the predictability of federal award commitments to secure financing, sustain operations, and plan capital investments. A regulatory framework that permits termination on the basis of nothing more than a brief written rationale from an agency official introduces a level of financial unpredictability that is incompatible with sound organizational management and inconsistent with the federal government's own interest in maintaining a stable and accessible safety-net health care infrastructure.

[§200.342–343] The absence of any guaranteed right to object, appeal, or seek compensation compounds the workforce, operational, and financial harms described above and leaves health centers and other safety-net providers with no meaningful

[11] Health center revenue derives from a combination of federal grants, Medicaid and Medicare reimbursement, and other public program funding; federal grant awards from HRSA and other agencies support services that health center delivery revenue alone cannot sustain. In 2024, Medicaid was the largest single revenue source for health centers, accounting for 45 percent of $49.8 billion in total health center revenue, with federal grant funding providing essential support for services that patient care revenue cannot cover. KFF, Community Health Center Patients, Financing, and Services (Feb. 4, 2026, updated Feb. 11, 2026), *available at* kff.org.

[12] Moody's Ratings identified the Proposed Rule as a credit negative for public finance issuers with high dependence on competitive federal funding — including colleges and universities, hospitals, and other entities — concluding that the expanded termination and suspension authority would materially weaken the reliability of multi-year discretionary funding commitments. Caitlin Devitt, *Moody's Warns Proposed Political Review of Grants a Credit Negative*, Bond Buyer (June 15, 2026) (reporting analysis by Moody's analyst Nicholas Samuels).

recourse when a federal agency exercises its broad discretionary authority to terminate or suspend an active award.[13] The Proposed Rule leaves to agency discretion whether a grantee may object to, appeal, or request a hearing related to the discretionary termination or suspension, providing no guaranteed procedural protections for organizations that have structured multi-year programs, hired staff, and incurred financial obligations in direct reliance on a federal award.

This is a significant departure from the due process norms that apply in analogous federal contexts. OMB itself analogizes proposed section 200.340(a) to termination for convenience in federal procurement, yet the Proposed Rule fails to extend the settlement procedures and allowable termination cost recovery that make the Federal Acquisition Regulation framework equitable for the party whose contract is terminated.[14] The Proposed Rule would afford federal grantees fewer procedural protections than those available in an analogous termination context, and it would do so in circumstances where the stakes are at least as high, that is, the continuity of health care services for medically underserved communities that have no other place to turn.

The Proposed Rule also does not expressly require agencies to authorize costs incurred after termination, leaving grantees to absorb the full cost of winding down programs they were required by their award terms to operate.[15] For health care organizations, those wind-

[13] Under current regulations, when a federal agency initiates a remedy for noncompliance, including termination, it must provide the recipient with an opportunity to object and present information challenging the action and must comply with applicable requirements for hearings and appeals. 2 C.F.R. 200.342. The Proposed Rule would eliminate these protections for discretionary terminations and suspensions, expressly providing that agencies are not required to allow objections, hearings, or appeals for terminations initiated on discretionary grounds other than noncompliance. 91 Fed. Reg. 32198, 32260 (proposed May 29, 2026) (proposed 2 C.F.R. § 200.342).

[14] Under the Federal Acquisition Regulation, a contractor whose fixed-price contract is terminated for the convenience of the government is entitled to fair compensation, including recovery of allowable costs incurred in performance, a reasonable profit on work performed, and settlement expenses. FAR 49.201(a) (providing that a settlement should compensate the contractor fairly for the work done and preparations made, including a reasonable allowance for profit); FAR 52.249-2 (entitling terminated contractors to recover allowable costs incurred, a reasonable profit on work performed, and settlement expenses). The Proposed Rule imports the procurement concept of termination for convenience into the grant context while omitting the financial protections that make that framework equitable. Under proposed section 200.343, costs incurred as a result of a discretionary termination are allowable only at the agency's reasonable discretion, considering competing policy concerns, leaving recipients with no assured right to recover costs they have already incurred in performance of a federal award. 91 Fed. Reg. 32198, 32260–32261 (proposed May 29, 2026) (proposed 2 C.F.R. §§ 200.340, 200.343).

[15] Under the Proposed Rule, post-termination costs resulting from a discretionary termination may be allowed only in the agency's reasonable discretion, weighed against competing policy concerns. 91 Fed. Reg. 32198, 32260–32261 (May 29, 2026) (proposed 2 C.F.R. 200.343). Under current regulations, costs incurred during a suspension or after termination are not allowable unless the agency expressly authorizes them in the notice of suspension or termination or subsequently. 2 C.F.R. 200.343. Neither the current nor the proposed framework guarantees recovery of wind-down costs for discretionary terminations.

down costs are substantial and concrete: lease and equipment financing obligations, severance, subaward closeout costs, and the clinical and legal costs associated with safely transitioning patients to other providers. A damages award through the United States Court of Federal Claims, the primary recourse the Proposed Rule contemplates, cannot reopen a closed clinic, reconstitute a departed workforce, or restore the community trust that safety-net providers spend years building. Monetary relief is not an adequate remedy for the loss of ongoing health care services to vulnerable patients.

The absence of meaningful procedural protections within the regulatory framework is compounded by the inadequacy of available judicial remedies. Two recent Supreme Court orders issued on the emergency docket have substantially narrowed the practical avenues for challenging grant terminations in federal court. In *Department of Education v. California, No. 24A910*, 604 U.S. 650, 145 S. Ct. 966 (Apr. 4, 2025) (per curiam), the Court stayed a district court order enjoining the government from terminating education grants and requiring continued payment of grant obligations, finding the government likely to succeed in showing that claims seeking restoration of terminated grant funding belong in the Court of Federal Claims under the Tucker Act, 28 U.S.C. 1491, rather than in federal district court under the APA. In *National Institutes of Health v. American Public Health Association*, No. 25A103, 606 U.S. ___ (Aug. 21, 2025), the Court issued a 5–4 decision staying a district court order that had vacated NIH grant terminations while leaving intact the vacatur of the underlying agency guidance. Justice Barrett's concurring opinion, which provided the controlling rationale, concluded that challenges to individual grant terminations must proceed in the Court of Federal Claims, while challenges to agency-level guidance directing terminations may remain in district court, requiring recipients to pursue relief in two separate forums to obtain complete relief. The Court of Federal Claims may award monetary damages but lacks general authority to grant standalone equitable or injunctive relief, such as an order halting a termination or requiring reinstatement of a terminated award. 28 U.S.C. 1491(a). Recipients seeking to preserve ongoing program operations while litigation proceeds therefore have no practical mechanism for obtaining timely preliminary relief, and courts continue to disagree about the precise scope of Tucker Act preclusion in the grant context, creating uncertainty about forum, available relief, and litigation timeline. For the millions of patients who depend on health centers and other safety-net providers for care they cannot obtain elsewhere, uncertainty about whether a clinic will remain open is not an acceptable substitute for the procedural protections the Proposed Rule eliminates.

We strongly oppose the proposed expansion of discretionary suspension and termination authority under sections 200.340(a) and 200.340(e) and the elimination of procedural protections under sections 200.342–343. These provisions together would expose grantees to unpredictable financial, legal, and reputational risks; strip away the procedural safeguards that protect against arbitrary mid-award action; and leave health centers and other safety-net providers with no meaningful regulatory recourse and no practical judicial remedy when an agency terminates or suspends an active award without cause. Abrupt

termination or suspension of federal awards would cause severe and potentially irreversible disruptions to the community-based health care and public health services that medically underserved populations depend on for primary care, behavioral health, chronic disease management, preventive services, and other essential care that is not available to them through other means.

We urge OMB to withdraw these provisions and replace them with oversight mechanisms grounded in program performance, consistent with the statutory frameworks governing the relevant grant programs, and respectful of the vulnerable communities that rely on federally funded care. If OMB declines to withdraw the discretionary termination and suspension provisions, we urge OMB at minimum to establish a mandatory appeals process that requires grantees and the relevant agency to engage in good faith efforts to continue or restore the award before termination becomes final.

II. Politicization of Program Planning and Review Processes

[§200.202, 200.205, 200.206] For decades, grantees have relied on a competitive review process grounded in demonstrated performance, community need, and compliance with program requirements. Under the proposed revisions to section 200.205, this objective framework would be displaced by a mandatory pre-issuance review and approval process requiring sign-off by senior political appointees before any discretionary award may be issued. Under this process, political appointees would be required to certify that proposed awards advance Presidential and agency priorities, reducing recommendations of independent merit reviewers to advisory status rather than binding determinations and subordinating objective, criteria-based evaluation to political judgment. 91 Fed. Reg. 32198, 32248–32249 (proposed May 29, 2026) (proposed 2 C.F.R. 200.205(b)).

The consequences extend beyond a change in process. The Proposed Rule would authorize agencies to exclude grant proposals that are not consistent with federal agency priorities and the national interest, without any obligation to notify applicants of the basis for exclusion or provide an opportunity to respond. 91 Fed. Reg. 32198, 32249 (proposed May 29, 2026) (proposed 2 C.F.R. 200.205(b)). The Proposed Rule would also direct agencies to consider an applicant's affiliations with organizations deemed to undermine public safety or national security, and an applicant's engagement in activities inconsistent with federal civil rights laws. *Id*. (proposed 2 C.F.R. 200.206(b)). These criteria are so broad and undefined that they could be used to disqualify grantees that advance racial equity, serve populations the current administration disfavors, or simply hold policy positions that differ from those of the administration in power. Taken together, these provisions would allow any administration to condition the award of federal grants on ideological alignment rather than community need, program performance, or congressional intent. For health centers, this result is particularly untenable. Congress has expressly required health centers to provide services to all residents of their designated catchment area. Section 330 of the Public

Health Service Act, 42 U.S.C. 254b(a)(1). A political pre-issuance review process that conditions award approval on the demographic composition of a health center's patient population, the nature of the services it provides, or its affiliations with organizations that advance health equity would place health centers in the impossible position of either fulfilling their statutory obligation to serve all catchment area residents or satisfying the ideological requirements of a political review process. Congress did not design the health center program to operate on those terms, and OMB does not have authority through the Uniform Guidance to impose them. Nor does OMB have authority to use federal award terminations as a mechanism to punish entire geographic areas based on partisan voting patterns or the policies of state and local governments, by withholding funding from agencies and community organizations in those jurisdictions.

While programmatic oversight of federal awards serves a legitimate purpose, inserting mandatory political appointee review into the award process risks displacing statutory and programmatic criteria to shifting administrative priorities. We are gravely concerned that under this framework, the very services these organizations provide to underserved and marginalized communities could become grounds for disfavor, regardless of program performance, regulatory compliance, or demonstrated community need. We are equally concerned about the impact this review layer would have on the predictability and timeliness of award decisions. Community-based health care organizations, including health centers and other safety-net providers, depend on timely and predictable award cycles to sustain workforce planning, clinical staffing, contract execution, and continuity of care. Delays or denials driven by political review rather than program merit would directly harm the medically underserved patients and communities these organizations exist to serve.

The practical consequences of political review would be substantial. Grantees dedicate significant staff time and organizational resources to each application cycle, including clinical leadership, finance, compliance, and administrative personnel who spend a substantial amount of time assembling the documentation, data narratives, and budgets that a rigorous application requires. In many cases, grantees engage outside consultants and legal counsel, incurring direct costs that are justified only by the expectation that the review will be conducted on the merits and that a strong application has a genuine opportunity to succeed. Introducing political review would make it more difficult for applicants to predict how awards would ultimately be assessed and selected. To the extent award decisions become increasingly dependent on evolving policy priorities rather than established programmatic criteria, applicants may face greater uncertainty regarding funding outcomes despite satisfying all statutory and technical requirements. This diminished predictability risks undermining transparency in the grantmaking process and discourages innovative, community-based initiatives that otherwise advance many statutorily mandated purposes of federally funded public health programs.

The concerns created by the proposed revisions to section 200.205 are compounded by several related provisions that similarly expand consideration of policy-based factors throughout the grantmaking process. Section 200.202 would require programs to align with law and Executive Branch policy during program planning and design. *See* 91 Fed. Reg. 32198, 32247 (proposed May 29, 2026) (proposed 2 C.F.R. 200.202). Section 200.206(b) allows consideration of an applicant's history of questionable practices, including plagiarism or discredited studies. *See* 91 Fed. Reg. 32198, 32249–32250 (proposed May 29, 2026) (proposed 2 C.F.R. 200.206(b)). The same provision also allows consideration of an applicant's activities deemed "inconsistent with" civil rights or religious liberty laws, but the Proposed Rule does not tether that determination to any actual legal standard for what such inconsistency means, leaving agencies free to label as unlawful conduct that courts have upheld, including the kind of disparity tracking and equity-related programming the Proposed Rule elsewhere seeks to restrict through proposed section 200.218. *Id*. Collectively, these provisions shift grantmaking away from objective, peer-reviewed, and programmatic criteria toward increasingly discretionary and policy-driven determinations, creating additional uncertainty for grantees and the communities they serve.

The consequences of politically driven award decisions are not hypothetical. On June 26, 2026, the Department of Health and Human Services terminated 53 of 67 active grants under the Teen Pregnancy Prevention Program, worth approximately $68 million, affecting grantees in more than two dozen states.[16] The grants were canceled two years before their expiration dates not because of any documented failure by individual grantees to comply with grant terms, but because HHS determined, following a review of curricular content, that the funded programs normalized adolescent sexual activity or contained material the agency deemed age-inappropriate, and were therefore inconsistent with agency priorities. No individualized performance review was conducted. At least one grantee reported that its termination notice was effective the same day it was received, with no transition time for the organization, its staff, or the adolescents the program served. These were evidence-based programs delivering health education and reproductive health services to underserved youth, exactly the kind of community-based public health programming that federal grant programs were designed to support. The Proposed Rule would embed exactly this kind of authority into binding federal regulation, converting what is currently contested executive action into an insulated regulatory baseline and foreclosing the judicial challenges that succeeded when HHS took the same action in 2017. OMB should not finalize provisions that would make this outcome both permanent and unreviewable.

We therefore urge OMB to remove the pre-issuance political review requirement from section 200.205 and preserve the integrity of existing independent merit review processes as the core basis for award decisions, to ensure that the significant investments made in a

[16] Kelcie Moseley-Morris, *Federal Health Agency Cancels Most of Its Teen Pregnancy Prevention Grants*, Stateline (June 26, 2026), available at stateline.org.

grantee's competitive applications are evaluated against objective, criteria-based standards rather than shifting administrative priorities.

III. Limitations on Serving Marginalized and Disfavored Populations

[§§200.300, 200.205, 200.218, 200.340] Health centers and other safety-net providers serve as the primary, and in many communities, the only source of accessible, affordable, comprehensive primary care for marginalized, underserved, and historically disfavored communities that experience significant barriers to care. For example, the Health Center Program was established under Section 330 of the Public Health Service Act, 42 U.S.C. 254b, expressly to expand access to primary and preventive care, reduce health disparities, and improve health outcomes for vulnerable populations. Section 330 requires health centers to serve all residents of their designated catchment area. 42 U.S.C. 254b(a)(1). To fulfill these statutory obligations, health centers must assess community needs, conduct outreach to populations that face barriers to care, provide enabling services that facilitate access to treatment, and ensure that services are responsive to the communities they serve. Congress has long recognized this role. Under proposed sections 200.300(b), 200.218, 200.205, and 200.340, fulfilling these congressionally mandated obligations could become a liability, forcing health centers and other safety-net providers who receive federal grants to choose between retaining federal funding and complying with their statutory mission.

Proposed sections 200.300(b) and 200.218 are defective on three independent grounds: they fail to give grantees meaningful notice of what conduct is prohibited; they conflict directly with the statutory obligations Congress has imposed on health center grantees; and they impose conditions on federal funding that Congress did not authorize and that the Spending Clause does not permit.

Because the Proposed Rule does not define with specificity the activities that would be considered prohibited, grantees may reasonably question whether community outreach initiatives, language-access services, culturally and linguistically appropriate care, accessibility programs required to serve individuals with disabilities under Section 504 of the Rehabilitation Act, 29 U.S.C. 794, and the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and efforts to identify and address disparities in health or social outcomes could be deemed impermissible. Similarly, grantees may question whether they may continue to collect and use demographic and statistical information to assess community needs, evaluate program effectiveness, and identify barriers to care. This ambiguity creates an untenable position for grantees, forcing them to choose between continuing activities necessary to comply with federal statutory obligations and avoiding potential enforcement actions that could jeopardize critical federal funding. As a result, the uncertainty creates a compliance environment in which grantees are incentivized to underreport the populations they serve, undercount the services they provide, and understate the needs of their

communities to reduce their regulatory exposure. Faced with uncertain restrictions and the risk of adverse funding consequences, grantees may curtail or discontinue initiatives that support marginalized and disfavored communities.

Proposed section 200.300(b) would prohibit the use of federal awards to fund, promote, encourage, subsidize, or facilitate Diversity, Equity, and Inclusion (DEI) or Diversity, Equity, Inclusion, and Accessibility (DEIA) policies and practices and gender ideology as defined in Executive Order 14168. Proposed section 200.218 would prohibit the use of federal awards to promote or support theories of disparate-impact liability. These terms are generally not defined with sufficient precision to give grantees meaningful notice of what conduct is prohibited. The term "gender ideology" is particularly problematic in the health care context, as it is undefined in the Proposed Rule beyond its incorporation by reference to Executive Order 14168, and its application to clinical care decisions, patient education, and health services delivery for transgender and gender nonconforming individuals remains wholly unclear.[17] Critically, many DEIA-related practices and policies that the administration characterizes as unlawful have been upheld by courts as permissible under existing law, and grantees lawfully provide services to immigrant communities, asylum seekers, LGBTQ individuals, and other populations that the administration has sought to exclude from federal program eligibility. Any grantee found to be perpetuating these activities is subject to termination under Section 200.340 or denial during pre-issuance review under Section 200.205.

The vagueness of proposed sections 200.300(b) and 200.218 compounds a deeper statutory problem. The populations most affected by these provisions are those that have experienced historic and ongoing federal disinvestment, including communities of color, immigrant communities, people with disabilities, and others for whom federally funded public health programs represent the primary or sole source of accessible care. For example, the Proposed Rule would force health centers to choose between their statutory obligation to serve all residents of their catchment area and the ideological requirements of a political review process. It would also compel many organizations to choose between their commitments to health equity, immigrant services, and LGBTQ inclusion, and their ability to access the federal resources they need to serve their communities. That is not a choice Congress authorized OMB to impose, and it is not consistent with the statutory purposes of the federal public health programs these organizations exist to fulfill. These provisions also raise serious constitutional concerns under the Spending Clause, addressed in the Conclusion below.

We urge OMB to recognize the cumulative harm that proposed sections 200.300(b), 200.205, 200.218, and 200.340 would impose on community-based health care organizations and the communities they serve. We urge OMB to withdraw proposed

[17] Exec. Order No. 14168, Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, 90 Fed. Reg. 8615 (Jan. 30, 2025).

sections 200.300(b) and 200.218 in their entirety, to remove the pre-issuance political review requirement from proposed section 200.205, and to reaffirm that accurate, complete reporting and quality improvement activities that track health and social outcome disparities are not only permissible but required under existing federal law.

At a minimum, if OMB proceeds with any of these provisions, the final rule must expressly clarify that recipients may continue to undertake activities required or authorized by federal statute, including community outreach, language-access services, culturally and linguistically appropriate care, accessibility programs required under Section 504 of the Rehabilitation Act and the Americans with Disabilities Act for individuals with disabilities, community health needs assessments, quality improvement activities, population health initiatives, and the collection and use of demographic and statistical information for program planning and evaluation of program effectiveness. The final rule should also establish a safe harbor for activities undertaken to comply with federal statutory frameworks, including Section 330 of the Public Health Service Act, 42 U.S.C. 254b, Section 1557 of the Affordable Care Act, and other applicable federal requirements. The final rule should further make clear that the use of demographic and statistical analyses to identify barriers to care and assess community health needs does not constitute promotion or support of disparate-impact theories or misalignment with Presidential priorities.

Absent such clarifications, the Proposed Rule risks undermining congressionally mandated public health programs, creating substantial uncertainty among grantees, impairing evidence-based care delivery, and causing avoidable and lasting harm to the vulnerable communities these programs were designed to serve.

IV. Restrictions on Issue Advocacy and Public Communications

[§200.450] The Proposed Rule would introduce significant new restrictions on grantee communications and public engagement activities. Proposed section 200.450 would prohibit the use of federal award funds for issue advocacy or public messaging that promotes or opposes a particular social, political, or public policy position unrelated to the statutory objectives or performance requirements of the federal award and would further restrict grantee attempts to influence the executive branch of any state government on matters unrelated to the award. See 91 Fed. Reg. 32198, 32262 (proposed May 29, 2026) (proposed 2 C.F.R. 200.450).

These restrictions raise serious concerns for public health grantees whose statutory missions require them to engage with policymakers, educate communities, and advocate for the populations they serve. Health centers and other safety-net providers routinely engage in public communications and community education activities that are integral to program delivery, including outreach to underserved populations, public health education

campaigns, community needs assessments shared with local stakeholders, and participation in public forums on health policy issues affecting their patient communities. The line between permissible program-related communications and prohibited issue advocacy is not defined with sufficient clarity to give grantees meaningful notice of what activities are permissible.

The proposed restrictions are also in tension with existing federal requirements. For example, health centers are required under Section 330 of the Public Health Service Act, 42 U.S.C. 254b, to assess and respond to community health needs, engage with community stakeholders, and ensure that services are responsive to the populations they serve. These activities necessarily involve public communication and community engagement that could be characterized as issue advocacy under an expansive reading of the proposed restrictions. A grantee that publishes data on health disparities in its service area, advocates for expanded Medicaid coverage for its patients, or participates in public comment processes on regulations affecting its community could reasonably conclude that such activities fall within the scope of the proposed prohibition, even where those activities are directly connected to program objectives and required by statute.

The proposed restrictions also raise serious concerns under the First Amendment and the unconstitutional conditions doctrine. The government may not condition the receipt of federal funds on the relinquishment of constitutional rights, including the right to engage in protected speech and advocacy. *Agency for Int'l. Dev. v. All. for Open Soc'y. Int'l., Inc.*, 570 U.S. 205, 214 (2013) (holding that the First Amendment prohibits conditioning federal grants on domestic grantees' adoption of viewpoints inconsistent with their mission). Public health grantees that publish data on health disparities, testify before state legislatures about the needs of their patient communities, or participate in public comment processes on regulations affecting their service areas are engaged in core protected speech. Proposed section 200.450 would require these organizations to choose between retaining federal funding and exercising constitutional rights that bear a direct relationship to their statutory mission — precisely the kind of coercive condition the unconstitutional conditions doctrine prohibits. *Id.* at 214 ("the Government may not deny a benefit to a person on a basis that infringes his constitutionally protected . . . freedom of speech"). To the extent that proposed section 200.450 restricts communications and advocacy activities that are constitutionally protected and statutorily required, it raises serious constitutional concerns and is inconsistent with both the First Amendment and the congressional purposes the relevant grant programs exist to advance. This coercive-conditions problem is compounded by the Spending Clause concerns addressed in the Conclusion below.

We urge OMB to withdraw the proposed issue advocacy restrictions or, at a minimum, to define the scope of prohibited activities with sufficient precision to give grantees meaningful notice, and to expressly clarify that communications and public engagement

activities required or authorized by federal statute are not subject to restriction under these provisions.

V. Increased Administrative and Compliance Burdens

[§§ 200.421, 200.432, 200.454, 200.461, 200.467] OMB proposes to restrict the use of federal awards for conference costs, membership, subscription, and professional activity costs, advertising and public relations costs, publication, and printing costs, and selling and marketing cost. 91 Fed. Reg. 32198, 32261–32263 (proposed May 29, 2026) (proposed 2 C.F.R. 200.421, 200.432, 200.454, 200.461, 200.467). In addition, § 200.305 would require non-state recipients to provide detailed written justification for each payment request, including administrative activities, project milestones, project activities, or other requirements that must be completed under the federal award, adding new pre-reimbursement review requirements. 91 Fed. Reg. 32198, 32254 (proposed May 29, 2026) (proposed 2 C.F.R. 200.305). Collectively, these provisions would reduce flexibility in the use of federal awards while increasing administrative burden for already resource-constrained public health grantees.

Grantees operate in an environment of limited financial and staffing resources and already devote substantial effort to complying with federal grant requirements, program reporting obligations, quality-improvement initiatives, and audit standards. Requiring detailed written justification and supporting documentation for routine payment requests may significantly increase administrative workload for finance, compliance, and program staff. Resources that would otherwise be directed toward individual care, care coordination, workforce recruitment, and program implementation may instead be diverted to preparing, reviewing, and responding to additional documentation requests. For smaller programs in particular, these additional requirements would be detrimental to the survival of their efforts.

The proposed restrictions also raise serious questions under the Administrative Procedure Act. While OMB possesses broad authority under 31 U.S.C. 503 to establish government-wide financial management policies, that authority does not permit OMB to restrict allowable cost categories in ways that conflict with specific statutory requirements imposed on grant recipients, or to depart from longstanding cost principles without a reasoned explanation for doing so. An agency that restricts these costs without a reasoned explanation tied to program performance, fraud prevention, or statutory authority acts arbitrarily and capriciously within the meaning of the Administrative Procedure Act. 5 U.S.C. 706(2)(A); *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). OMB has not provided the cost-benefit analysis or reasoned explanation that a departure of this magnitude from longstanding cost principles requires.

We therefore urge OMB to preserve administrative flexibility in the use of federal awards and avoid unnecessary compliance burdens to ensure that federal investments continue to support timely, appropriate, and effective care. These changes would likely delay reimbursement, increase documentation requirements, and divert limited staff capacity away from community care and service delivery. Federal oversight is an important component of grant stewardship, but accountability measures should be designed to support the accessibility, availability, and delivery of essential health services in medically underserved communities.

VI. Conclusion

The specific provisions addressed in these comments do not represent isolated technical revisions to federal grants administration. Taken together, they constitute a fundamental restructuring of the relationship between the federal government and the health centers, safety-net providers, and community-based organizations that depend on federal awards to deliver essential care to medically underserved communities. At every stage of the award lifecycle, from initial application through mid-award performance to termination, the Proposed Rule would substitute unchecked executive discretion for the objective, merit-based framework that Congress intended and that grantees have relied upon to plan, staff, and deliver community-based health care services. The result would be a grant administration system in which award decisions bear no guaranteed relationship to program performance, community need, or congressional intent, and in which the communities most dependent on federally funded care are most exposed to the consequences of that uncertainty.

These concerns are not limited to policy disagreement. The Proposed Rule raises serious questions of legal authority that OMB must address before proceeding to a final rule.

The Proposed Rule was issued with a 45-day comment period for a rulemaking that would fundamentally alter the government-wide framework governing hundreds of billions of dollars in federal financial assistance. OMB has not provided a cost-benefit analysis that adequately accounts for the impact on existing grantees with active multi-year awards, on the communities that depend on those awards for ongoing health care services, or on the broader public health infrastructure that federal grant programs have built over decades. The failure to consider these reliance interests, combined with the compressed comment period and the absence of meaningful economic analysis, raises serious questions about whether the Proposed Rule satisfies the Administrative Procedure Act's requirement that agency action not be arbitrary and capricious. 5 U.S.C. 706(2)(A).

The breadth and significance of the proposed changes also implicate the major questions doctrine. The Proposed Rule would restructure the government-wide framework governing more than $1.2 trillion in annual federal financial assistance, precisely the kind of decision

of vast economic and political significance that requires clear congressional authorization.[18] *West Virginia v. EPA*, 597 U.S. 697 (2022). The Proposed Rule would vest OMB and federal agencies with authority to terminate any active discretionary award based on a political appointee's determination that it no longer serves the national interest, to condition all future awards on ideological alignment with Presidential priorities, and to prohibit entire categories of evidence-based public health programming through a government-wide regulation. Congress has not clearly authorized OMB to exercise that degree of control over the substantive priorities and operational decisions of federal grantees, and OMB's general financial management authority under 31 U.S.C. 503 does not supply the clear statement that the major questions doctrine requires.

Finally, several provisions of the Proposed Rule raise significant concerns under the Spending Clause of the United States Constitution. Congress may attach conditions to federal grants, but those conditions must be unambiguous, must bear some relationship to the federal interest in the program, and must not be so coercive as to leave grantees no meaningful choice but to comply. *South Dakota v. Dole*, 483 U.S. 203 (1987); *NFIB v. Sebelius*, 567 U.S. 519 (2012). OMB may not accomplish through regulation what Congress itself could not impose without satisfying these constitutional requirements. The DEIA prohibitions in proposed sections 200.300(b) and 200.218, and the political pre-issuance review requirement in proposed section 200.205, impose conditions that were not authorized by Congress when it established the federal grant programs to which they would apply, that bear no relationship to the programmatic purposes of those programs, and that would require health centers and other safety-net providers to choose between complying with their statutory obligations and retaining their federal funding. The fact that these conditions were directed by Executive Order does not supply the congressional authorization that the Spending Clause requires, as OMB's regulatory authority cannot exceed the authority Congress granted to the programs themselves. Courts have already blocked attempts by this administration to impose similar conditions through executive action. The Proposed Rule appears designed to convert those judicially rejected conditions into binding federal regulation. OMB should not finalize provisions that courts have already found inconsistent with federal law and the Constitution.

We respectfully urge OMB to withdraw the Proposed Rule. If OMB declines to withdraw the rule in its entirety, we urge OMB at minimum to withdraw proposed sections 200.205(b), 200.206, 200.218, 200.300(b), 200.340(a), and 200.340(e); to withdraw proposed section 200.450 or, if OMB declines to withdraw that provision, to define the scope of its prohibited activities with sufficient precision to give grantees meaningful notice and to clarify expressly that communications and public engagement activities required or authorized by federal statute are not subject to restriction; to revise proposed sections 200.305, 200.421,

[18] In FY 2024, the federal government obligated approximately $1.2 trillion for grants and cooperative agreements. U.S. Department of the Treasury, Financial Report of the United States Government, Financial Management section (Feb. 2025), available at fiscal.treasury.gov. This figure does not include loans and other forms of direct financial assistance, which would bring the total higher.

200.432, 200.454, 200.461, and 200.467 to preserve administrative flexibility and avoid compliance burdens that would divert limited grantee resources from community care and service delivery; to extend the comment period to allow for meaningful public engagement with a rulemaking of this magnitude; and to conduct and publish a full cost-benefit analysis that accounts for the impact of the proposed changes on existing grantees, ongoing programs, and the health centers, safety-net providers, and community-based organizations that depend on federally funded health care and public health services to fulfill their statutory missions.

Thank you for your consideration of our comments. If you need any additional information, please contact lha@powerslaw.com.

A. Public Health Organizations

1. American Public Health Association
2. California Primary Care Association
3. Defend Public Health
4. Jacobs Institute of Women's Health
5. Liberty Health Alliance
6. Massachusetts League of Community Health Centers
7. Mid-Atlantic Association of Community Health Centers
8. National Center for Medical-Legal Partnership
9. Oregon Primary Care Association

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