AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

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July 13, 2026

Russell Vought
Director
Office of Management and Budget
Executive Office of the President
Attention: OMB-2026-0034
725 17th Street, NW
Washington, DC 20503

RE: Regulation for Federal Financial Assistance (OMB-2026-0034)

Dear Director Vought:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on the proposed rule, *Regulation for Federal Financial Assistance*, to the Office of Management and Budget (OMB). AGS is concerned that, if finalized, the rule will become a substantial barrier to maintaining health and quality of life for all Americans as we age and threaten the United States' leadership in innovation and discovery, particularly in health-oriented research that allows discovery and implementation of life-saving interventions and supports the prevention and preparedness of public health concerns.

The mission of AGS, a not-for-profit society, is to improve the health, independence, and quality of life of all older people. Our 6,000+ members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician associates, pharmacists, and internists who are pioneers in serious illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. AGS is an anti-discriminatory organization. We believe in a society where we all are supported by and able to contribute to our communities. The Society leads efforts to incorporate attention to older adults living with multiple chronic conditions into research [1, 2] and clinical care [3, 4] and is a champion for improving attention to the unique health care needs of older

[1] Advancing Geriatrics Research: AGS/NIA Conference Series. American Geriatrics Society. Accessed June 25, 2026. https://www.americangeriatrics.org/programs/advancing-geriatrics-research-agsnia-conference-series
[2] The AGS/AGING LEARNING Collaborative. AGS CoCare. Accessed June 26, 2026. https://mccresearch.agscocare.org/what_is_the_ags_aging_learning_collaborative
[3] American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity. Guiding principles for the care of older adults with multimorbidity: an approach for clinicians. *J Am Geriatr Soc*. 2012;60(10):e1-e25. doi:10.1111/j.1532-5415.2012.04188.x
[4] McNabney MK, Green AR, Burke M, et al. Complexities of care: common components of models of care in geriatrics. *J Am Geriatr Soc.* 2022;70(7):1960–1972. doi:10.1111/jgs.17811

adults in workforce training.[5, 6] We believe that understanding disease across the lifespan[7] is important to extending healthspan — the time someone lives in generally good health — for all of us as we age.

We appreciate OMB's goals of improving federal grantmaking for the benefit of the American public and its stated intent of providing greater transparency, accountability, and oversight of federal grants through rulemaking. The changes that OMB is proposing in this rule have far-reaching, harmful implications for US localities, cities, and states who receive federal funding to serve their respective communities for health care, housing, education, transportation, disaster relief, child and social services, and public health and safety. Congress has designed many of the programs that support older Americans to have funding flow through state and local agencies. AGS is concerned that the additional burdens and risks proposed in the rule would unduly increase cost pressures on local governments at a time when state budgets are already too tightly stretched. The threat of far-reaching and long-term harm is also significant for older Americans given the importance of federally funded merit review research, workforce development, housing, and other federally funded programs to their health and well-being.

AGS is dedicated to improving health and quality of life, advancing translational research that links biology to clinical outcomes, ensuring implementation of the most effective interventions, and strengthening care systems and care delivery for all of us as we age. In this letter, AGS will focus on federally funded research, clinical care, and workforce training programs that are advancing the understanding of the unique health care needs of older Americans and then translating that knowledge into clinical care and professional and public education. **We strongly encourage OMB to not implement this rule.**

IMPORTANCE OF FEDERAL FINANCIAL ASSISTANCE TO PROGRAMS SUPPORTING HEALTH AND WELL-BEING OF OLDER AMERICANS

AGS members are at the forefront of federal research funded by the National Institute on Aging (NIA) of the National Institutes of Health (NIH); geriatrics research, clinical, and workforce programs supported by the Department of Veterans Affairs (VA); and geriatrics workforce programs supported by the Health Resources and Services Administration (HRSA). Geriatrics health professionals rely on the long-term services and supports and community-based programs that are administered by the Administration for Community Living (ACL) and public health guidance that is supported by the Centers for Disease Control and Prevention (CDC).

These programs are vital to the health and well-being of older Americans and there has been insufficient time for the American public to review the proposed rule, much less the related agency updates and changes to policies. We are deeply concerned that a number of OMB's proposals will negatively impact the progress we have made in extending the healthspan of Americans through federally financed programs that are overseen through multiple agencies. Examples of the types of programs and initiatives

[5] American Geriatrics Society. Written Testimony to Senate Labor-HHS-Education Appropriations Subcommittee on FY 2027 Funding for Geriatrics Workforce Training Programs. May 22, 2026. Accessed June 25, 2026. https://www.americangeriatrics.org/sites/default/files/AGS FY 2027 Written Testimony for Senate LHHS - GWEP GACA %285 22 26%29.pdf

[6] AGS Advancing Geriatrics in Surgical & Medical Specialties. Special Collection. *J Am Geriatr Soc*. Accessed June 25, 2026. https://agsjournals.onlinelibrary.wiley.com/hub/journal/15325415/agsadvancinggeriatrics

[7] National Institutes of Health. Inclusion Across the lifespan in human subjects research. Updated February 27, 2025. Accessed June 25, 2026. https://grants.nih.gov/policy-and-compliance/policy-topics/inclusion/lifespan

that are funded by NIA/NIH, the VA, HRSA, ACL, and CDC that contribute to the health, independence, and quality of life of older Americans include:

- Many **longitudinal and population studies conducted by NIA resulted in what we now know about healthy aging today.**[8] With its whole person approach to the diseases and disorders of aging, NIA has made incredible progress in improving our collective healthspan, in large part, thanks to the foresight of Congress in establishing an Institute that works towards a healthier future for all of us. NIA-supported research has advanced discoveries to prevent or delay the onset of diseases and functional decline related to aging as well as to identify factors that promote healthy aging and independence. These studies include:

    - The **Baltimore Longitudinal Study of Aging (BLSA)** under NIA, one of the longest running studies globally since 1958, has been helping to build fundamental knowledge and understanding about aging and disease and influencing new pathways for research for more effective approaches to disease prevention. For example, BLSA data helped determine that natural aging over time does not mean diseases, such as hypertension and dementia, are unavoidable.[9] Through BLSA, we continue to make groundbreaking discoveries such as strategies to prevent or slow arterial aging before cardiovascular disease (CVD) occurs, reducing incorrect diagnoses of prostate cancer, slowing down the natural limitations of getting older (e.g., mobility, function) through regular physical activity to increase years of optimal health,[10] reversing frailty for older adults with obesity,[11] and much more.

    - The NIA-supported **Aspirin in Reducing Events in the Elderly (ASPREE) study** — a landmark, "gold standard" clinical trial (i.e., randomized, double blind, placebo-controlled) with nearly 20,000 older adults — was the largest trial regarding aspirin's impact in healthy older adults and the first to provide evidence that the drug does not prolong healthy years of life for those without significant disease or disability.[12] Although the trial was completed in 2017, ASPREE continues to have cumulative benefits to the research community and paves the path for novel discoveries including seven sub-studies related to cancer, depression, epigenetics, and more. It also supports additional studies, such as the NIA-awarded cross-sectional study with data from over 11,000 adults aged 70 and older through ASPREE and its sub-study, ASPREE Longitudinal Study of Older Persons (ALSOP), which found that social isolation, loneliness, and low levels of social support increase the risk of CVD. The findings from the cross-sectional

[8] National Institute on Aging. What do we know about healthy aging? February 23, 2022. Accessed July 9, 2026. https://www.nia.nih.gov/health/healthy-aging/what-do-we-know-about-healthy-aging#taking-care-of-your-physical-health
[9] National Institute on Aging. What is normal aging? Lessons from the BLSA. Updated July 27, 2018. Accessed July 9, 2026. https://www.nia.nih.gov/research/labs/blsa/what-normal-aging
[10] Reid KF, Martin KI, Doros G, et al. Comparative effects of light or heavy resistance power training for improving lower extremity power and physical performance in mobility-limited older adults. *J Gerontol A Biol Sci Med Sci.* 2015;70(3):374-380. doi:10.1093/gerona/glu156
[11] Villareal DT, Aguirre L, Gurney AB, et al. Aerobic or resistance exercise, or both, in dieting obese older adults. *N Engl J Med.* 2017;376(20):1943-1955. doi:10.1056/NEJMoa1616338
[12] McNeil JJ, Nelson MR, Woods RL, et al. Effect of aspirin on all-cause mortality in the healthy elderly. *N Engl J Med.* 2018;379(16):1519-1528. doi:10.1056/NEJMoa1803955

study are helping to build the knowledge on and inform how we can manage both social and heart health.[13]

- NIA has been an effective steward of **Alzheimer's disease and related dementias (ADRD)** research funding, including working to ensure that brain health is not siloed under a single portfolio but considered across the research that NIA and other NIH Institutes and Centers (ICs) support. The reality is that more than 90% of Medicare beneficiaries who have ADRD also have other chronic diseases and are nearly three times more likely to have four or more chronic diseases than beneficiaries without ADRD.[14] Without NIA-supported research that considers other key facets of health, we do a disservice to older Americans living with dementia and other chronic diseases as well as their care partners. As an example, the NIA-supported Systolic Blood Pressure Intervention Trial (SPRINT), a randomized controlled trial, provided the first evidence of lower systolic blood pressure reducing risk of cognitive decline and dementia.[15, 16] Furthermore, the ongoing Pragmatic Evaluation of Events and Benefits of Lipid-lowering in Older Adults (PREVENTABLE) national clinical trial — with support from NIH ICs, including NIA, and the VA — is not only focused on the benefit of statins but also includes assessing cognitive outcomes, such as extending dementia and disability-free longevity in people 75 years and older.[17]

- Established by Congress in 1990, NIA's **Claude D. Pepper Centers Program Older Americans Independence Centers (OAICs)** seek to increase scientific knowledge that allows older adults to maintain or restore their physical independence. Funded through a P30 Clinical Trial Optional Mechanism, OAICs have made major contributions to several pivotal large, multi-center studies in older persons, including Lifestyle Interventions and Independence for Elders (LIFE);[18] STRIDE;[19] Rehabilitation and Exercise Training After Hospitalization (REHAB-HF);[20] PREVENTABLE,[21] Study of Muscle, Mobility, and Aging (SOMMA),[22] Molecular Transducers of

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[13] Hu J, Fitzgerald SM, Owen AJ, et al. Social isolation, social support, loneliness and cardiovascular disease risk factors: a cross-sectional study among older adults. *Int J Geriatr Psychiatry.* 2021;36(11):1795-1809. doi:10.1002/gps.5601

[14] Alzheimer's Association. Fact sheet: Alzheimer's and multiple chronic conditions. April 2026. Accessed July 9, 2026. https://www.alz.org/getmedia/4102d0c5-51a8-4de0-8771-a044b715690e/alzheimers-and-multiple-chronic-conditions.pdf

[15] The SPRINT Research Group. A randomized trial of intensive versus standard blood-pressure control. *N Engl J Med*. 2015;373(22):2103-2116. doi:10.1056/NEJMoa1511939

[16] Reboussin DM, Gaussoin SA, Pajewski NM, et al. Long-term effect of intensive vs standard blood pressure control on mild cognitive impairment and probable dementia in SPRINT. *Neurology*. 2025;104(3):e213334. doi:10.1212/WNL.0000000000213334

[17] Pragmatic Evaluation of Events and Benefits of Lipid-lowering in Older Adults (PREVENTABLE). Clinicaltrials.gov. Updated June 4, 2026. Accessed July 9, 2026. https://clinicaltrials.gov/study/NCT04262206

[18] Pahor M, Guralnik JM, Ambrosius WT, et al. Effect of structured physical activity on prevention of major mobility disability in older adults: the LIFE study randomized clinical trial. *JAMA*. 2014;311(23):2387-2396. doi:10.1001/jama.2014.5616

[19] Bhasin S, Gill TM, Reuben DB, et al. A randomized trial of a multifactorial strategy to prevent serious fall injuries. *N Engl J Med*. 2020;383(2):129-140. doi:10.1056/NEJMoa2002183

[20] Kitzman DW, Whellan DJ, Duncan P, et al. Physical rehabilitation for older patients hospitalized for heart failure. *N Engl J Med*. 2021;385(3):203-216. doi:10.1056/NEJMoa2026141

[21] Joseph J, Pajewski NM, Dolor RJ, et al. Pragmatic evaluation of events and benefits of lipid lowering in older adults (PREVENTABLE): trial design and rationale. *J Am Geriatr Soc*. 2023;71(6):1701-1713. doi:10.1111/jgs.18312

[22] Cummings SR, Newman AB, Coen PM, et al. The Study of Muscle, Mobility and Aging (SOMMA): a unique cohort study about the cellular biology of aging and age-related loss of mobility. *J Gerontol A Biol Sci Med Sci*. 2023;78(11):2083-2093. doi:10.1093/gerona/glad052

Physical Activity Consortium (MoTrPAC),[23] and Dementia Care Study (D-Care).[24] Collectively, OAIC-supported research has produced numerous key insights to enhance physical function and maintain independence in older persons, spanning the full translational spectrum from molecular mechanisms to clinical and community interventions.[25]

- Funded by NIA, the **Paul B. Beeson Emerging Leaders Career Development Awards in Aging program (Beeson Program (Beeson, K-Series)[26] and Grants for Early Medical/Surgical Specialists' Transition to Aging Research program (GEMSSTAR, R03)[27]** are examples of how federal funding supports early-stage investigators (ESIs) to advance the tools, skills, and expertise needed to establish independent academic careers in aging research within their clinical discipline.

- Congress established the **VA Geriatric Research, Education, and Clinical Centers (GRECCs)** in 1975 to enhance the mission of the Veterans Health Administration (VHA) – the largest integrated health system in the country. GRECCs have continued to improve health care and quality for the growing population of older veterans as incubators of innovation and excellence in research, education, and clinical care. Funded through the VA Central Office for the first three years, GRECCs then generate indirect funding for research and educational activities, which are returned to the Veterans Integrated Service Network (VISN), and partner with other federally funded institutions. The research portfolio that GRECCs stewards is one that spans across the bench to bedside continuum and the spectrum of biomedical, clinical, prevention, public health, and other high impact health services research. GRECCs, committed to optimizing health systems serving veterans to ensure they can thrive long after their service to our country, also develop innovative technologies that support older veterans in receiving care at home and reduce hospitalizations and use of long-term care facilities while advancing new clinical care models and developing educational initiatives for the health workforce, veterans, and care partners.[28] Furthermore, VHA is the nation's second largest federal funder of graduate medical education and plays a critical role in developing the next generation of health scientists who are focused on improving care for older veterans given their discoveries often lead to improvements in how we care for all Americans.

- VA-funded research programs, such as the **Million Veteran Program (MVP)**, support addressing the chronic and emerging health and wellness needs of our nation's veterans, including post-traumatic stress disorder, kidney disease, Parkinson's disease, substance use disorders, and more. The largest program in the world that studies genes and health, MVP is also the largest research initiative at the VA with over 800 researchers and more than 100 ongoing projects.

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[23] Sanford JA, Nogiec CD, Lindholm ME, et al. Molecular Transducers of Physical Activity Consortium (MoTrPAC): mapping the dynamic responses to exercise. *Cell*. 2020;181(7):1464-1474. doi:10.1016/j.cell.2020.06.004

[24] Reuben DB, Gill TM, Stevens A, et al. D-CARE: the Dementia Care Study: design of a pragmatic trial of the effectiveness and cost effectiveness of health system–based versus community-based dementia care versus usual dementia care. *J Am Geriatr Soc*. 2020;68(11):2492-2499. doi:10.1111/jgs.16862

[25] Kitzman DW, Halter JB, Bandeen-Roche K. The Pepper Older Americans Independence Centers: an NIA-sponsored program for improving physical function among older persons. *J Am Geriatr Soc.* 2024;72(5):1586-1589. doi:10.1111/jgs.18866

[26] Barr RA, van der Willik O, Yaffe K, Gill TM. The NIA Paul B. Beeson Emerging Leaders Career Development Program: an enduring public–private partnership. *J Am Geriatr Soc.* 2024;72(5):1639-1641. doi:10.1111/jgs.18802

[27] Gill TM, Sherman AN, van der Willik O, Yaffe K, Walston JD. Training and supporting subspecialty clinician–scientists in aging research through GEMSSTAR and Clin-STAR. *J Am Geriatr Soc.* 2024;72(5):1634-1638. doi:10.1111/jgs.18811

[28] Farrell TW, Hogans BB, Moo L, et al. Impact of Veterans Affairs Geriatric Research, Education, and Clinical Centers: incubators of innovation in geriatrics. *J Am Geriatr Soc.* 2024;72(11):3315-3326. doi:10.1111/jgs.19082

Since 2018, research under MVP published more than 400 articles in peer-reviewed journals that support the critical dissemination of research findings and their relevance to the care of older veterans as well as all Americans.[29] The VA's role as a major contributor to medical and scientific research and meeting its statutory mission of training a new generation of investigators to serve the needs of veterans and the nation is imperative.

- HRSA funds the **Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA) program** under Title VII of the Public Health Service Act. These are the *only* federal programs designed to address the geriatrics workforce gap[30] through geriatrics training at the community-level (GWEP) and to increase the number of faculty with geriatrics expertise across disciplines (GACA). GWEPs train the health care and supportive care workforces to maximize patient and family engagement, and to integrate geriatrics and primary care. Several tools are used to disseminate this training, including the use of reciprocal partnerships, the promotion of age-friendly and dementia-competent care, the impact of evaluation, and flexibility and innovation in the delivery of interprofessional training.[31] Geriatrics clinical care, education, and research depend on having sufficient numbers of geriatrics faculty across the health professions to train the next generation of clinicians, educators, and investigators. The GACA program supports early-stage educators to acquire the skills they need to lead efforts to ensure that the United States healthcare workforce is prepared to care for older Americans.

- ACL awards more than $1 billion dollars in grants, primarily to **states and organizations who provide services and supports for older adults and people with disabilities**. This includes Meals on Wheels and services for older persons funded under the Older Americans Act (OAA) Nutrition Program, which covers 32% of the program's costs and serves over 2 million Americans annually. Meal on Wheels providers rely heavily on federal financial assistance – currently 8 out of 10 local programs receive federal funding and for more than 60% of providers, federal funding represents half or more of their total budget.[32]

- The **CDC provides grants that support public health programs in chronic disease prevention**, health promotion, immunizations, emergency preparedness and response, and health equity. For example, CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) provides funding to organizations to conduct activities that help prevent and manage chronic conditions. More than 75% of NCCDPHP's budget goes to states, local, territorial, and tribal partners to support community-based prevention programs that help people prevent, manage, and avoid complications associated with chronic disease.[33] In addition, the CDC Stopping Elderly Accidents, Deaths, and Injuries (STEADI) toolkit and initiative — based

[29] Department of Veterans Affairs Office of Research & Development. MVP Research. Accessed July 10, 2026. https://www.research.va.gov/mvp/research.cfm
[30] Farrell TW, Korniyenko A, Hu G, Fulmer T. Geriatric medicine is advancing, not declining: a proposal for new metrics to assess the health of the profession. *J Am Geriatr Soc*. 2024;73(1):323-328. doi:10.1111/jgs.19143
[31] Geriatrics Workforce Enhancement Program Compendium. Special Collection. *J Am Geriatr Soc.* April 17, 2024. Accessed July 9, 2026. https://agsjournals.onlinelibrary.wiley.com/doi/toc/10.1111/(ISSN)1532-5415.GWEP-Compendium
[32] Meals on Wheels America. 2026 National Snapshot. May 2026. Accessed July 10, 2026. https://www.mealsonwheelsamerica.org/wp-content/uploads/2026/01/Meals-on-Wheels-Funding-Explained_Fact-Sheet_Jan2026.pdf
[33] Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion. About us. May 14, 2026. Accessed July 10, 2026. https://www.cdc.gov/nccdphp/about/index.html

on the 2011 AGS / British Geriatrics Society falls prevention guideline [34] — was released in 2012 and last updated in 2024 to encourage health professionals to screen older patients for their fall risk, identify the modifiable fall risk factors (e.g., poor balance, vision impairment), and intervene to reduce risk using effective clinical strategies (e.g., physical therapy, medication management) and community strategies (community-based exercise programs like Tai chi). CDC, in partnership with ACL, funds health departments and health systems to integrate and implement STEADI into practice for the reduction of fall risk and incidents. Falls are reported by more than 14 million older adults annually [35] and had an estimated total healthcare expenditure of $80 billion of which $53.3 billion was paid for by Medicare in 2020. [36]

All of these programs are important to older Americans and their communities, and we are concerned that the far-reaching changes that OMB is proposing put them at risk of loss of funding, potentially for situations that are beyond their control.

SPECIFIC COMMENTS

Below are our comments and recommendations which are presented in the order of topics addressed in the proposed rule.

§ 200.205 - Federal Agency Review of Merit of Proposals

In its proposed pre-issuance process, OMB seeks to:

- Vest final decision-making authority in senior political appointees;
- Position peer review as solely advisory in nature; and
- Preference institutions with lower indirect cost rates.

The Restoring Gold Standard Science Executive Order (EO) [37] establishes that "reproducibility, rigor, and unbiased peer review must be maintained" and are the benchmarks for federal research and scientific integrity. A number of the proposed revisions are contradictory to the intent of the EO which is to ensure transparent and impactful federally funded research.

Vest Final Decision-Making Authority in Senior Political Appointees

AGS is committed to ensuring that federal policy and decisions impacting the health of all Americans are informed by those who have the clinical and scientific skills, expertise, and experience necessary to lead and guide scientific research and health-related programs that serve all of us as we age. Senior political appointees are appointed by the President and are typically members of the President's political party. In practice, the partisan loyalty of political appointees is a key factor in ensuring political accountability and ensuring party control of executive branch decisions. Political appointees are chosen without the

[34] Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society. Summary of the updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. *J Am Geriatr Soc.* 2011;59(1):148-157. doi:10.1111/j.1532-5415.2010.03234.x

[35] Centers for Disease Control and Prevention. Older adult falls data. February 26, 2026. Accessed July 10, 2026. https://www.cdc.gov/falls/data-research/index.html

[36] Haddad YK, Miller GF, Kakara R, et al. Healthcare spending for non-fatal falls among older adults, USA. *BMJ.* 2024;30(4):272-276. doi:10.1136/ip-2023-045023

[37] Restoring gold standard science. *Fed Regist.* 2025;90(102):22601-22606.

competitive, merit-based process that is required for positions in the Civil Service. AGS is concerned that vesting final authority in such appointees will lead to interruptions in research; cessation of important federal workforce training programs; reductions in access to geriatrics expertise for older adults, including veterans; and a decline in the overall health of the public due to reductions in the public health workforce. There has been ample reporting on the impacts of the Department of Government Efficiency (DOGE) on our nation's reputation as a world leader in gold standard science and public health [38, 39] and prompted several legal actions, including injunctions for violating constitutional rights, the Administrative Procedure Act, and other federal statutes. [40, 41]

Position Peer Review as Soley Advisory in Nature

The Public Health Service Act, 42 USC § 289a, [42] does not merely encourage peer review at NIH – it mandates it by regulation, and a companion provision, 42 USC § 289a-1(a), [43] goes further: "the Secretary may not approve or fund any proposal" subject to peer review under § 289a "unless the proposal has undergone such review . . . and has been recommended for approval by a majority of the members of the entity conducting such review, and unless a majority of the voting members of the appropriate advisory council . . . has recommended the proposal for approval." Congress has also specified under 42 USC § 284 [44] that this review is a precondition to the award itself: a grant, cooperative agreement, or contract for research, training, or demonstrations "may be made only if" it has first been recommended after the peer review required by § 289a, and awards exceeding $50,000 in direct costs must additionally be recommended by the relevant national research institute's advisory council. This is not a discretionary or aspirational review step that OMB may relegate to advisory status; it is a mandatory statutory condition on agency authority to make the award at all.

Proposed § 200.205 would make peer review "advisory" and interpose senior political appointee review as effectively dispositive for all discretionary awards, including NIH grants covering AGS members' geriatrics and gerontological research. OMB's cited authorities — 31 USC § 503(a)(2)'s general "financial management" mandate and 31 USC § 6307's authorization to issue "supplementary interpretative guidelines" — cannot be naturally read as license to override a specific congressional funding gate enacted in a different title of the US Code administered by a different agency. Indeed, the very word "interpretative" in 31 USC § 6307 cuts against reading it as authority to displace a substantive statutory requirement rather than merely interpret ambiguities in grants administration. Under well-established canons of statutory interpretation, a specific, subject-matter statute of this kind is not displaced by a later, more general administrative provision, regardless of the order in which the two were adopted. See

[38] Dorgelo C, Leibenluft J. DOGE interference in federal grantmaking adds burden, uncertainty, and risk. Center on Budget and Policy Priorities. May 28, 2025. Accessed July 9, 2026. https://www.cbpp.org/research/federal-budget/doge-interference-in-federal-grantmaking-adds-burden-uncertainty-and-risk

[39] Kozlov M. NIH killed grants on orders from Elon Musk's DOGE. *Nature*. Published online May 21, 2025. doi:10.1038/d41586-025-01617-8

[40] *Thakur v Trump,* 800 F Supp3d 1044 (ND Cal 2025).

[41] *American Council of Learned Societies v National Endowment for the Humanities; The Authors Guild v National Endowment for the Humanities*, Docket No. 1:25-cv-03657, American Council of Learned Societies (SDNY March 23, 2026).

[42] Public Health Service Act. 42 USC § 289a: Peer review requirements (2000). Accessed July 9, 2026. https://uscode.house.gov/view.xhtml?req=granuleid:USC-1999-title42-section289a&num=0&edition=1999

[43] Public Health Service Act. 42 USC § 289a-1: Certain provisions regarding review and approval of proposals for research (2000). Accessed July 9, 2026. https://uscode.house.gov/view.xhtml?hl=false&edition=1999&req=granuleid%3AUSC-1999-title42-section289a-1&num=0&saved=%7CZ3JhbnVsZWlkOlVTQy0xOTk5LXRpdGxlNDItc2VjdGlvbjI4OWE%3D%7C%7C%7C0%7Cfalse%7C1999

[44] Public Health Service Act. 42 USC § 284: Directors of national research institutes (2000). Accessed July 10, 2026. https://uscode.house.gov/view.xhtml?req=granuleid:USC-1999-title42-section284&num=0&edition=1999

Morton v Mancari, 417 US 535, 550–51 (1974) ("Where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one, regardless of the priority of enactment."); *Radzanower v Touche Ross & Co*., 426 US 148, 153 (1976) (a statute addressing a narrow, precise, and specific subject is not submerged by a later, more generalized enactment, absent a clear and manifest indication that Congress intended to displace it); and *RadLAX Gateway Hotel, LLC v Amalgamated Bank*, 566 US 639, 645 (2012) (general authorizations do not override specific ones existing "side-by-side," even where the general language is broad enough to cover the same subject). These principles apply with equal, if not greater, force here, where the "general" provision is not a statute but would be an OMB regulation purporting to constrain how a specific statutory command — peer review as a condition of award — is implemented. For these reasons, if OMB were to move this rule forward, AGS urges OMB to withdraw § 200.205(b) as applied to NIH and other statutorily mandated peer review programs, or, at minimum, to add an express savings clause confirming that the pre-issuance review process does not diminish, delay, or substitute for the technical and scientific peer review Congress has required as a precondition to award under 42 USC §§ 289a[42] and 284.[44]

Preference Institutions with Lower Indirect Cost Rates

It is important that federal funding recognize and support the true cost of research and that institutions appropriately account for facilities and administrative costs when submitting annual indirect cost rate proposals for review and approval by the federal government.

The proposed preference would unfairly advantage more well-resourced institutions and those in regions with lower costs for doing business (e.g., personnel, supplies, rent, transportation) and lower negotiated indirect cost rates.[45] The consequences of such preferencing include the potential that decisions about which science to fund would be based on a financial metric and not on whether the proposed project advances our knowledge and understanding and contributes to our country's worldwide leadership of scientific discovery and care delivery.

§ 200.206 – Federal Agency Review of Risk Posed by Applicants

In its draft pre-issuance process, OMB is proposing new factors for assessing risk of applicants, including:

- Financial stability and capacity for high-dollar awards;
- Prior performance;
- History of "questionable practices;" and
- Organizational affiliations that undermine "public safety and national security."

While we appreciate OMB's efforts to protect the integrity of federal programs, AGS is concerned that several terms are vague and inadequately defined. Given the lack of specificity, these provisions may unjustly penalize qualified applicants from receiving funding based on exercising their rights as American citizens as defined in the US Bill of Rights.[46] EO 14332 attempted to limit Uniform Guidance across all activities that organizations undertake and not just those activities that are supported by federal

[45] Attain Partners. Indirect cost rate and recovery. January 20, 2026. Accessed July 9, 2026. https://www.aau.edu/sites/default/files/AAU-Files/Key-Issues/Research-Administration-Regulation/Costs-of-Research/FINAL-AAU-and-COGR-Indirect-Cost-and-Reimbursement-Report-1-21-26.pdf

[46] US Constitution. Amendments 1-10. National Archives. Accessed July 9, 2026. https://www.archives.gov/founding-docs/bill-of-rights

funding. [47] The court ruled in favor of organizations that challenged that EO on the premise that it would infringe upon their free speech rights, including *City of Fresno v Turner*, [48] *Commonwealth of Massachusetts v US Department of Agriculture*, [49] and *Housing Authority of the County of San Diego v Turner.* [50]

We are concerned that as currently written, the proposals will potentially infringe on the rights of all Americans and that OMB is overreaching its statutory authority. Should OMB adopt the rule, we recommend that, at a minimum, the administration add more specificity, including:

- Define the criteria that would be used to assess an organization's financial stability and capacity for high-dollar awards;
- Specify how applicants with no prior history of federal funding would be assessed for prior performance;
- Define what practices would be designated as questionable and what specific conducts would be prohibited; and
- Specify what criteria would be used in determining that an affiliated organization undermines "public safety and national security" and the level and duration of affiliation that would be determined as presenting a risk.

At a minimum, OMB should also add a notification and appeal process for individuals and affiliated organizations that have received a determination of questionable practices, prohibited conduct, and undermined public safety and national security. This process should specify that the agencies making these determinations must provide evidence supporting their determination, provide timely notification to affected individuals and organizations, and provide an expedited appeal process so as to not unduly interrupt federally funded projects, programs, and services. In updating this guidance, OMB should ensure that these provisions do not infringe on the rights of all Americans as defined in the Bill of Rights[46] due to overly broad interpretation of underlying statutes, poorly defined terminology, and a lack of guidance to members of the federal workforce charged with enforcing this guidance and recipients of financial assistance who are required to abide by them.

Financial Capacity and Prior Performance Provisions

OMB is proposing to consider an organization's capacity for high dollar awards and prior performance as a part of its consideration of funding. Here we would like to highlight potential negative impacts of this change on priorities that the administration has identified as important to achieving its goals.

- This proposed assessment is contrary to the administration's commitment to support a stable pipeline for ESIs [51] and stated goal of ensuring the distribution of research funding is broadened

[47] Improving oversight of federal grantmaking. *Fed Regist.* 2025;90(153):38929-38933.
[48] *City of Fresno v Turner,* Docket No. 3:25-cv-07070-RS, CourtListener (ND Cal September 23, 2025).
[49] *Commonwealth of Massachusetts v US Department of Agriculture*, Docket No. 1:26-cv-11396, CourtListener (Mass June 5, 2026).
[50] *Housing Authority of the County of San Diego v Turner,* Docket No. 4:25-cv-08859, CourtListener (ND Cal November 14, 2025).
[51] National Institutes of Health. NIH support for early stage investigators in FYs 2024 and 2025. NIH Extramural Nexus (News). February 10, 2026. Accessed June 29, 2026. https://grants.nih.gov/news-events/nih-extramural-nexus-news/2026/02/nih-support-for-early-stage-investigators-in-fys-2024-and-2025

to include a wider swath of institutions and geographic regions[52] including OMB's pre-issuance proposal (§ 200.205(b)(4)) that "awards should be given to a broad range of recipients." AGS believes that the proposals to assess financial stability and capacity for high dollar awards and prior performance will have a negative impact on ESIs, applicants with no previous track record of funding, and smaller grantees. If finalized, these provisions could further exacerbate the decline of ESIs in the United States scientific ecosystem and already existing gap between under-resourced institutions and well-resourced institutions. In fiscal years (FY) 2023 to 2025, the rate of ESIs awarded at the NIH decreased from 30% to 19%, an 11% reduction in two years.[51] According to a recent National Bureau of Economic Research survey, more than 25% of the young biomedical scientists are reconsidering their plans to stay in the United States and only 44% indicated likelihood of staying in academia.[53]

- The GWEP and GACA programs described above focus on the health of older Americans. The GWEPs, which operate in 37 states, include several programs that are focused on Americans living in rural and other underserved areas. They are making a meaningful difference in ensuring that the primary care and caregiver workforce in the United States is trained to deliver care to older Americans that is informed by the 4Ms of age-friendly care (What **M**atters, **M**edication, **M**entation, and **M**obility). Implementing the requirement for an assessment of financial capacity and prior performance will create additional barriers for smaller GWEPs, first-time GWEP applicants, and GWEPs working in underserved communities that are under-resourced. This will lead to gaps in access to geriatrics expertise in underserved and rural areas; ultimately, reducing the quality of care for those Americans.

§ 200.208 – Specific Conditions

OMB is proposing to modify the language in this section so that specific conditions can be added or removed under awards at an agency's discretion during the performance period, including switching from advanced payments to a reimbursement system.

Advance Payment versus Reimbursement System

We recognize that the administration seeks to ensure that federal funding is expended in service of advancing the program that is being funded. However, the proposal to change how financial assistance is paid during a performance period creates uncertainty for organizations receiving financial assistance and may discourage potential applicants from applying because of the uncertainty around how an award will be paid.

Shifting from advance payments to reimbursements midcycle of an award would be particularly problematic as such a change would also shift the financial plans and performance for awardees and has the potential for greater instability for recipients and the communities served. As an example, less well-resourced recipients may not be able to pay programmatic costs upfront and then wait for reimbursement, particularly given that there is no specificity in the proposed change as to the duration of the waiting period after a request is made for federal reimbursement.

[52] National Institutes of Health. Achieving NIH's mission: leveraging funding policies. November 2025. Accessed June 29, 2026. https://grants.nih.gov/sites/default/files/Leveraging-Funding-Policies-Framework.pdf

[53] Azoulay P, Sadun R, Scur D. Before the exodus? Young scientists and the future of US science. National Bureau of Economic Research. Published June 2026. Accessed July 9, 2026. doi:10.3386/w35330

We believe this would be detrimental for communities directly serving Americans with health and/or long-term services and supports needs such as programs funded by the VA, HRSA, and ACL (as described above). If such programming is disrupted or halted due to unexpected revenue issues because an agency has changed its payment rules midcycle, particularly in underserved and rural areas, valuable health resources that are making a meaningful difference in the lives of patients and their families for their well-being could be lost. This would be contrary to the administration's focus on combatting Americans' health challenges, including increasing access to care in rural communities.

ESIs are just starting to build their careers and NIH has prioritized support for this group of investigators. Disruptions to their funding due to a change in how a career development award is paid could create undue hardship, particularly for awardees who have included pursuit of additional training to better prepare them to lead research and other programs with corresponding tuition costs.

§ 200.300 – Statutory and National Policy Requirements

AGS is committed to taking purposeful steps to address discrimination in health care given its impact on older adults, their families, and our communities. We work across our strategic priorities to advance our vision of a society that is free of discrimination due to the impact on all of us as we age. Under § 1 of the 14th amendment of the US Constitution, all citizens are entitled to equal protection of the laws.[54] AGS' work advances the principles embodied in the Civil Rights Acts of 1866,[55] 1964,[56] and 1968,[57] the Americans with Disabilities Act of 1990,[58] and the Patient Protection and Affordable Care Act of 2010,[59] which prohibit discrimination based on race, color, disability, age, religion, sex, and national origin.

OMB, in consultation with the Department of Justice and other agencies, proposes to amend this in § 200.300(b), to provide that:

- "…in administering Federal awards, to the maximum extent permitted by law, the Federal agency or pass-through entity must ensure that the Federal award is not used to fund, promote, encourage, subsidize, or facilitate: "Diversity, equity, and inclusion" (DEI) or "diversity, equity, inclusion, and accessibility" (DEIA) policies, principles, or practices that violate any applicable Federal anti-discrimination laws. This includes racial preferences or other forms of racial discrimination used by the recipient or subrecipient that violate any applicable Federal anti-discrimination laws, including activities where race or intentional proxies for race will be used as a selection criterion for employment or program participation (the "Unlawful DEI Provision")".

[54] US Constitution. Amendment 14 § 1. National Archives. Accessed July 1, 2026. https://www.archives.gov/founding-docs/amendments-11-27
[55] Civil Rights Act, Pub L No. 39-26, 14 Stat 27 (1866).
[56] Civil Rights Act, 42 USC § 2000d et seq. (1964). National Archives. Accessed July 1, 2026. https://www.archives.gov/milestone-documents/civil-rights-act
[57] Civil Rights Act, 42 USC § 3601 et seq. (1968). Cornell Law School. Accessed July 1, 2026. https://www.law.cornell.edu/uscode/text/42/3601
[58] Americans with Disabilities Act. 42 USC § 12101 (1990). Accessed July 1, 2026. https://www.congress.gov/101/statute/STATUTE-104/STATUTE-104-Pg327.pdf
[59] Patient Protection and Affordable Care Act. 42 USC 18001 (2010). Accessed July 1, 2026. https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf

An analysis of research found that 33% of federally funded clinical trials had an upper age limit, with one-quarter of the studies not allowing people 65 and older to participate.[60] A multitude of studies have shown that the efficacy and effects of interventions can vary between populations[61, 62] and that epigenetic or environmental, social, and lifestyle factors impact diseases and responses to therapies.[63, 64] It is vitally important to all Americans as we age to address these variations which requires an evidence base to measure, understand, and address the differences.[65] Additionally, the Food and Drug Administration (FDA) reporting of adults 65 and older does not take into consideration the major changes in drug pharmacokinetics and pharmacodynamics that occur across the older age span — from 65 to very old ages (80 and older) — leading to underrepresentation of older adults who are very old in clinical trials.[66] In addition to race, ethnicity, and other demographic data, age should be reported meticulously to detect clinically important differences across and between older age groups and the inclusion of "very old" adults who would be at greater risk for adverse effects and likely receive a large portion of such interventions once approved. The lack of inclusion of older adults and young children in study populations is so serious that NIH convened stakeholders and sought input into its Inclusion Across the Lifespan Policy[7] which was first published in December 2017 and updated in February 2025.

The most recent projections from the Census Bureau show that the United States population is aging and becoming increasingly diverse.[67] Yet, this proposal puts at risk congressionally-established federal programs that are important in seeking to address longstanding disparities and to serve underserved communities, including the only federal programs building the geriatrics expertise we all need as we age in the primary care, paid caregiver, and family caregiver workforce — the GWEPs and GACA program. These two programs have been successfully leading and preparing the workforce and communities for the health care of older Americans, particularly in rural and other underserved areas.

Despite the large and growing number of adults aged 65 and older in the United States who are likely to require the care of a geriatrician, as of 2023, there were only 6,431 practicing geriatricians – making up 1.9% of our primary care physician population.[68] Similar shortages persist with health professionals specializing in geriatrics across other disciplines and rural populations have particularly acute lack of access to primary care physicians compared to residents of urban areas. Rural populations generally are

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[60] Lockett J, Sauma S, Radziszewska B, Bernard MA. Adequacy of inclusion of older adults in NIH-funded phase III clinical trials. *J Am Geriatr Soc*. 2019;67(2):218-222. doi:10.1111/jgs.15786

[61] Wang Y, Zhao X, Lin J, et al. Association between CYP2C19 loss-of-function allele status and efficacy of clopidogrel for risk reduction among patients with minor stroke or transient ischemic attack. *JAMA*. 2016;316(1):70-78. doi:10.1001/jama.2016.8662

[62] Elahi M, Eshera N, Bambata N, et al. The Food and Drug Administration Office of Women's Health: impact of science on regulatory policy: an update. *J Women's Health.* 2016;25(3):222-234. doi:10.1089/jwh.2015.5671

[63] Tiffon C. The impact of nutrition and environmental epigenetics on human health and disease. *Int J Mol Sci*. 2018;19(11):3425. doi:10.3390/ijms19113425

[64] Argentieri MA, Nagarajan S, Seddighzadeh B, Baccarelli AA, Shields AE. Epigenetic pathways in human disease: The impact of DNA methylation on stress-related pathogenesis and current challenges in biomarker development. *EBioMedicine*. 2017;18:327-350. doi:10.1016/j.ebiom.2017.03.044

[65] Loree JM, Anand S, Dasari A, et al. Disparity of race reporting and representation in clinical trials leading to cancer drug approvals from 2008 to 2018. *JAMA Oncol*. 2019;5(10):e19187. doi:10.1001/jamaoncol.2019.1870

[66] Lau SWJ. History of FDA Guidance on Drug Evaluation in Older Adult Patients. Roadmap to 2030 for New Drug Evaluation in Older Adults Workshop; March 23, 2021. Accessed June 30, 2026. https://www.fda.gov/media/147956/download

[67] US Census Bureau. 2023 national population projections datasets. November 9, 2023. Accessed June 30, 2026. https://www.census.gov/data/datasets/2023/demo/popproj/2023-popproj.html

[68] Health Resources and Services Administration Bureau of Health Workforce. State of the Primary Care Workforce, 2025. December 2025. Accessed July 1, 2026. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf

older, have a higher incidence of poor health, and face greater socioeconomic barriers to the care they need to live independently.[69] It is essential to ensure more rural and underserved areas of the country have access to clinicians with geriatrics training and expertise. GWEPs, community-based programs that train health professionals in geriatrics care, focus on opportunities to improve the quality of care delivered to older adults, particularly in underserved and rural areas. These programs also help build the larger and more geographically diverse pipeline of geriatrics research and training expertise we all need to provide skilled, effective, and efficient hands-on care to older adults across populations.

AGS urges OMB to clarify that its proposed prohibition on using federal awards to "fund, promote, encourage, subsidize, or facilitate" DEI or DEIA policies, principles, or practices that violate federal anti-discrimination law does not purport to supersede the specific, pre-existing statutory mandates concerning inclusion of particular populations. Under 42 USC § 289a-2,[70] for example, NIH is required to ensure that women and members of minority groups are included as subjects in NIH-funded clinical research, that clinical trials are designed to permit valid analysis of whether the studied variables affect these populations differently, and that, since FY 1995, the Director of NIH may not even approve a clinical research proposal unless it specifies how the research will comply with this inclusion mandate. This is not a race- or sex-based preference in employment or program participation of the kind the proposed rule targets; it is a scientific validity requirement Congress imposed to ensure that federally funded research produces results that are generalizable to the entire population that NIH-funded geriatrics and biomedical research is meant to serve, including older adults. To the extent OMB's general prohibition on considering race, sex, or similar characteristics as a "selection criterion" could be read — whether by OMB, an awarding agency, or a grant recipient acting out of an abundance of caution — to bar or chill compliance with § 289a-2's inclusion requirements, that reading cannot stand. A specific statutory mandate is not displaced by a later, general administrative rule absent a clear and manifest indication that Congress intended that result, and none exists here. AGS urges OMB to add an express clarification that nothing in the final rule limits, restricts, or discourages compliance with statutory inclusion requirements such as 42 USC § 289a-2.[70]

A parallel conflict arises with respect to the geriatrics workforce training programs. Under 42 USC § 294c(a),[71] the Secretary is statutorily required to give priority, in awarding GWEP grants, to applicants whose programs or activities are expected to substantially benefit rural or medically underserved populations of older adults or to serve older adults in Indian Tribes or Tribal organizations. This is a geographic- and access-based statutory priority, not a racial or sex-based classification, and it exists precisely because Congress recognized that older adults in rural, medically underserved, and Tribal communities face documented, disproportionate shortages of geriatrics-trained providers. Nonetheless, because the proposed rule's terms — "diversity, equity, inclusion, and accessibility" — are broad and undefined, there is a genuine risk that HRSA, a pass-through entity, or a grant applicant could read the rule to discourage or disqualify the very targeting Congress mandated in § 294c(a), particularly the priority for Tribal organizations and underserved populations. Congress' specific, program-level directive in § 294c(a) controls over OMB's general, cross-cutting rule under the same interpretive principles set out above, and AGS respectfully requests that OMB either exempt statutorily mandated population-targeting and priority provisions like § 294c(a) from the rule's scope or add clarifying language

[69] Cohen SA, Greaney ML. Aging in rural communities. *Curr Epidemiol Rep*. 2022;10(1):1-16. doi:10.1007/s40471-022-00313-9
[70] Public Health Service Act. 42 USC § 289a-2: Inclusion of women and minorities in clinical research (2000). Accessed July 13, 2026. https://uscode.house.gov/view.xhtml?req=(title:42%20section:289a-2%20edition:prelim)
[71] Public Health Service Act. 42 USC § 294c: Education and training relating to geriatrics (2000). https://uscode.house.gov/view.xhtml?req=(title:42%20section:294c%20edition:prelim)

confirming that compliance with such congressionally mandated priorities does not constitute a prohibited DEI or DEIA practice under the final rule.

Finally, AGS is concerned that OMB's proposed DEI/DEIA prohibition would place states in direct conflict with their existing statutory obligations under the OAA. Unlike the geographic- or access-based priorities discussed above, several OAA provisions explicitly and repeatedly require states and Area Agencies on Aging to account for racial and ethnic minority status in administering Title III funds. The Act's own definition of "greatest social need" includes isolation caused by racial or ethnic status, 42 USC § 3002, [72] and that definition is operationalized throughout the Act's administrative machinery: states must develop intrastate funding formulas that give "particular attention to low-income minority older individuals," 42 USC § 3025; [73] Area Agencies on Aging must set specific objectives for serving low-income minority older individuals, track their numbers within each planning and service area, and report on the effectiveness of outreach to this population, 42 USC § 3026; [74] and state plans must evaluate the effectiveness of services to minority older individuals and ensure technical assistance is available to minority service providers, 42 USC § 3027. [75] These requirements have been part of OAA's administrative framework since the 1992 amendments and are conditions of an approved state plan, without which a state cannot receive Title III funding at all.

A state or Area Agency on Aging cannot simultaneously comply with these congressionally mandated targeting requirements and avoid any practice that could be characterized as accounting for race in program administration. As discussed above with regard to § 200.205, because Congress' statutory scheme predates OMB's proposed rule, is highly specific in identifying racial and ethnic minority status as a required targeting factor, and remains a precondition to state plan approval and continued Title III funding it controls over OMB's general, cross-cutting prohibition under well-established interpretive canons: a specific statute is not displaced by a later, more general provision absent a clear and manifest indication that Congress intended that result. Notably, these OAA provisions consistently treat racial and ethnic minority status as one factor among several bearing on need — always tied to economic circumstances, language barriers, or geographic isolation — rather than as a categorical preference, quota, or exclusive selection criterion; AGS submits that this distinguishes OAA's targeting scheme from the kind of practice the proposed rule appears intended to reach, and that OMB should say so expressly. AGS accordingly requests that OMB add an express savings clause confirming that compliance with 42 USC §§ 3002, 3025, 3026, and 3027, and with the state plan and area plan requirements that implement them, does not constitute a prohibited DEI or DEIA policy, principle, or practice under the final rule.

§ 200.333 – Fixed Amount Subawards

OMB proposes to eliminate all fixed-price awards and subawards. If implemented, the rule would shift the predictable fixed amount funding received by states and their subrecipients, such as Area Agencies on Aging, to cost-reimbursement models requiring burdensome justifications and documentation supporting each payment request, including drawdowns for advance payments. This unduly burdens

[72] Older Americans Act. 42 USC § 3002: Definitions (2000). https://uscode.house.gov/view.xhtml?req=granuleid:USC-1999-title42-section3002&num=0&edition=1999
[73] Older Americans Act. 42 USC § 3025: Designation of State agencies (2000). https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section3025&num=0&edition=prelim
[74] Older Americans Act. 42 USC § 3026: Area plans (2000). https://uscode.house.gov/view.xhtml?req=(title:42%20section:3026%20edition:prelim)
[75] Older Americans Act. 42 USC § 3027: State plans (2000). https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section3027&num=0&edition=prelim

state agencies with increased administrative burden and creates cash flow risk by requiring state and local agencies to advance costs before receiving reimbursement.

§ 200.340 – Termination and Suspension

OMB is proposing that grants can be terminated at will if determined to not support the national interest "as they exist at the time of termination" and without opportunity for an appeals process in addition to providing agencies and pass-through entities authority to issue stop work orders up to 90 days at any time if determined to be in their interest. The thousands of active federal awards, grants, and programs across agencies that were suspended or terminated unexpectedly since early 2025 had a monumental effect on the American public, including our health, well-being, and related scientific discoveries, [76, 77] that have been successfully challenged in the courts. [78, 79, 80] These proposals not only unduly limit procedural protections for grantees but would have a substantial adverse impact on biomedical research and health-related programs that serve to improve the health of all Americans.

Interventions from NIH-funded research have helped to reduce declines in function and susceptibility to disease or frailty and in turn delayed the onset of costly age-related diseases. Recent technical advances enable new aging research, including better molecular tools, data science to model the complexity and systems science inherent to aging, and real-world data opportunities to ensure access to older people that were previously difficult to study in trials. [81]

Introducing the possibility of sudden termination of research funding has the potential to negatively impact the stability that has led to United States' global leadership in research, including aging research. We are already seeing reports of how other countries are working to attract American researchers, capitalizing on the instability and unpredictability that has been introduced into the United States research enterprise due to pre-emptive cancellations. [82, 83, 84, 85] Cancelling active awards at any time without findings of misconduct would also directly threaten longitudinal studies, including at the VA where long-term studies are among the agency's greatest research assets and the BLSA trial and other longstanding NIH studies described above. Moreover, researchers may be reluctant to disseminate and communicate their findings that appear to be contradictory to national or an agency's interest due to potential repercussions, risking the validity and reliability that is essential for rigorous research.

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[76] Faiman B. The impact of federal funding cuts on research, practice, and patient care. *J Adv Pract Oncol.* 2025;16(4):124-125. doi:10.6004/jadpro.2025.16.4.1

[77] Association of American Medical Colleges. The impact of federal actions on academic medicine and the U.S. health care system. *AAMC Leads.* June 11, 2025. Accessed July 9, 2026. https://www.aamc.org/about-us/aamc-leads/impact-federal-actions-academic-medicine-and-us-health-care-system

[78] *American Association of University Professors v Trump.* Docket No 3:25-cv-07864, CourtListener (ND Cal November 14, 2025).

[79] *American Public Health Association v National Institutes of Health.* 786 F Supp3d 237 (Mass 2025).

[80] *Commonwealth of Massachusetts v Kennedy.* 783 F Supp3d 487 (Mass 2025).

[81] Covinsky KE, Mody L, Inouye SK. Why do we (and still do!) need the National Institute on Aging—50 years of innovation. *JAMA Intern Med*. 2024;184(10):.1143-1144. doi:10.1001/jamainternmed.2024.1326

[82] Scoles S. Dozens of countries are trying to lure U.S. scientists abroad—and it's working. *Sci Am.* 2026;335(1):80. doi:10.1038/scientificamerican072026-1htlzYdv5k6VWckvcn8AFh

[83] Udesky L, Leeming J. Exclusive: a *Nature* analysis signals the beginnings of a US science brain drain. *Nature.* April 22, 2025. Accessed July 9, 2026. doi:10.1038/d41586-025-01216-7

[84] Risseeuw L. Trump's America is losing top scientists, and the Netherlands just picked up 29 of them. *DutchReview.* July 7, 2026. Accessed July 9, 2026. https://dutchreview.com/news/netherlands-recruits-scientists-fleeing-trump-america/

[85] Joseph A. Amid talk of a brain drain, some scientists leave U.S. behind. *STAT.* December 17, 2025. Accessed July 9, 2026. https://www.statnews.com/2025/12/17/research-cuts-fuel-scientific-brain-drain-american-science-shattered/

We are also concerned about the uncertainty for key workforce training programs, such as the GWEPs and GACAs. Due to GWEPs' partnerships with primary care and community-based organizations, GWEPs are uniquely positioned to rapidly address the needs of older adults and their caregivers, especially around ADRD and complex health concerns. The GACA program is an essential complement to GWEPs, ensuring we can equip early-career clinician educators to become leaders in geriatrics education and research. The GWEPs and GACAs have also been successful in leading state and local public health planning. These programs are critical in providing assistance for proactive public health planning with their geriatrics expertise — including in cognition, polypharmacy, and mobility challenges — and knowledge of long-term care and have helped to ensure states and local governments are equipped with effective plans for older adults in disaster preparedness and pandemics. AGS believes that interruptions and instability in the GWEP and GACA programs will significantly widen the existing workforce gap in primary care and geriatrics and reduce access to essential health care for millions of Americans.

AGS further urges OMB to expressly confirm that OAA formula grants under Titles III, VI, and VII fall outside the scope of proposed § 200.340's expanded discretionary termination and suspension authority. Congress structured these programs as statutory formula allotments, not discretionary awards – Title III and Title VII funds are distributed to State and Territorial Units on Aging and Area Agencies on Aging according to population-based statutory formulas set out in 42 USC §§ 3025, et seq.,[73] administered through a detailed, congressionally mandated state plan approval process. This structure reflects a considered legislative judgment that services to older adults — home-delivered and congregate meals, family caregiver supports, elder abuse prevention, and long-term care ombudsman programs among them — require funding stability and predictability that a case-by-case, discretionary termination regime would undermine.

States and Area Agencies on Aging build multi-year budgets, staffing plans, and contracts with local service providers on the reasonable expectation that formula funding, once allotted under an approved state plan, will not be subject to termination based on shifting agency priorities or an evolving assessment of the "national interest" as it exists "at the time of the termination." The proposed rule already recognizes, in principle, that statutory entitlements, block grants, and formula-based awards warrant different treatment than discretionary awards; AGS respectfully submits that OAA Titles III, VI, and VII allotments are a paradigmatic example of the kind of award this carveout is meant to protect, and that OMB should say so explicitly rather than leave the question to case-by-case interpretation by individual awarding agencies.

The cost of ambiguity here falls disproportionately on states and the older adults they serve. State Units on Aging and Area Agencies on Aging administer OAA formula funds as the financial backbone of an entire service delivery network; a discretionary or unclear application of § 200.340 to these programs would force states to build contingency reserves, delay multi-year contracts with nutrition and caregiver-support providers, or otherwise divert scarce state resources away from direct services to older adults simply to hedge against the risk of federal funding disruption – an outcome squarely at odds with Congress' design of the OAA as a stable, formula-driven safety net. AGS therefore requests that OMB amend the final rule to state expressly that OAA Titles III, VI, and VII formula allotments are excluded from § 200.340's discretionary termination and § 200.340(e)'s new 90-day suspension authority, consistent with the treatment already afforded to other statutory entitlement and formula-based programs under the proposed rule.

Given the unpredictability and lack of financial protection for research and health care programs should these provisions be finalized, we are concerned that decades of bipartisan progress in understanding

aging, preventing chronic disease, and extending the healthspan of millions of Americans will be at risk, undermine the stability of state and local budgets, and violate congressional intent with regard to older adult programs. We urge OMB to support the continued leadership of the United States in science, the future of biomedical research, and the collective health and well-being of all of us as we age.

§ 200.432 – Conferences

OMB is proposing a restriction on costs for grantees attending conferences to clarify that federal funds cannot be used unless it advances program outcomes and the requirement for explicit agency approval and inclusion in the award's terms and conditions. Under this provision, agencies would be able to exclude conference attendance as allowable costs even if attendance contributes to advancing outcomes of federal programs and research. The proposal disincentivizes opportunities and the returns on investment that make the work of federally funded initiatives effective.

Further, conferences are an important way in which federally funded research is disseminated more widely with more transparency and accountability. We believe dissemination and communication about research and scientific findings, including through conferences, is a fundamental component of research and for improving the health of all Americans. Advancing and building knowledge requires a robust infrastructure for sharing what we have learned with other investigators, industries, health professionals, and the public. This allows different communities to learn from each other; spark new ideas for avenues of inquiry; prevent duplicative efforts; create opportunities for collaboration; translate findings into interventions and treatments; and advance science that informs and supports all of us to live healthier lives.

Participation in conferences also allows wider dissemination of federally funded research into clinical practice. For example, the AGS Annual Scientific Meetings gather geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician associates, pharmacists, internists, trainees, and other health professionals. These annual conferences provide interactive, engaging, and comprehensive education with clinical updates and insights on research across the lifespan, clinical care, innovative models of care and quality improvement, and much more. They also allow unique opportunities for peer learning and networking with colleagues in the geriatrics community and among federal funding recipients. AGS, like many other organizations, provides opportunities for mentorship, career development, and supports longitudinal growth of researchers and practitioners over time. Scientific meetings bring together pioneers in a field, mid-career clinicians, and those who are just beginning to explore a career caring for older adults. The valuable opportunities provided through conferences are critical to supporting the advancement of positive outcomes for federally funded research and programs.

AGS also hosts meetings that bring together federal awardees for shared learning and growth. As an example, the GWEPs learn from each other through biannual conferences that are specifically convened to meet their educational needs. At these conferences, they share innovative strategies for enhancing the skills and knowledge of primary care clinicians and community-based organizations who care for older adults. These meetings strengthen geriatrics education, workforce development, and age-friendly practices across institutions and regions.

§ 200.454 – Memberships, Subscriptions, and Professional Activity Costs

We recognize OMB's efforts to ensure allowable costs are necessary to fulfill proposed award requirements.

AGS membership connects investigators and other individuals and organizations with federal funding to a community of over 6,000 professionals and valuable benefits that help AGS members stay abreast of clinical care and innovations, new research, and policy initiatives which in turn supports members in their federally funded activities in research and health-related programs. We provide clinical guidelines and recommendations that are evidence-based, patient handouts that are easy to understand resources for patients and caregivers, collaborative opportunities for career advancement and leadership, and publications and products that support clinical care and aging research. Benefits of membership include access to the *Journal of the American Geriatrics Society (JAGS)*, mentoring, and networking opportunities.

The GWEP-Coordinating Center (GWEP-CC) administered by AGS also serves GWEP grantees by providing programming and resources tailored to their needs and focused on preparing the healthcare workforce to care for older adults. Our GWEP-CC brings together GWEP awardees for national meetings, providing resources to be used towards clinical content products, memberships, and meeting travel, as well as offering other educational and networking opportunities, including webinars and advocacy training.

§ 200.461 – Publication and Printing Costs

OMB is proposing to change the policy to disallow costs of publication — which currently account for less than 1% of direct costs in NIH grants [86] — without sufficiently considering the critical element of communication in conducting research. AGS publishes *JAGS* as a hybrid journal which derives income from subscriptions, transformative agreements negotiated by our publishing partner Wiley, and fees paid to publish articles open access. As a journal, *JAGS* publishes research, policy, education, and other articles that are focused on improving clinical care for all of us as we age. With its special focus on disseminating research that advances the health and well-being of older adults, *JAGS* is an important part of a broader ecosystem of high-quality, peer-reviewed journals that provide an essential service to the American public because of the transparency and rigor with which the editors approach peer review of articles. The robust peer review of submissions that *JAGS* and other journals provide means that we are publishing gold standard science, in alignment with the Restoring Gold Standard Science EO, that contributes to improving healthcare for all of us.

Publication of research findings is integral to the research enterprise, and NIH and other federal agencies benefit from the contributions that journals make to disseminating the knowledge gained from the scientific investigations that federal research supports. We believe that our collective ability to advance the most promising innovations benefits from *JAGS* and other journals' robust peer review that validates scientific findings and their relevance to clinical care. Peer-reviewed journals also provide an important service to investigators with their careful attention to the clarity of communication about findings with a particular focus on ensuring that these are not overstated, fostering transparency and accountability that improves public trust in science.

[86] Anderson K. NIH poised to regulate APCs. *The Geyser.* July 31, 2025. Accessed July 1, 2026. https://www.the-geyser.com/nih-poised-to-regulate-apcs/

Furthermore, guidelines and recommendations produced by AGS and other societies rely on publication of research in peer-reviewed scientific literature for the evidence base that informs our creation of clinical recommendations that are focused on improving our collective health and well-being as we age. The evidence produced by federally funded researchers is helping to reduce susceptibility to disease and delays the onset of age-related and chronic diseases. As the United States population rapidly ages, access to innovative and effective care techniques for medically complex older adults informed by robust evidence is critically important. That access comes via publication and dissemination of research, and we are concerned that disallowing publication costs will mean that important findings from federally funded research will not be published thus not communicated to the American public, a substantial downfall for the return on investment of federal research.

There is emerging research that open access articles generally have higher citations than articles with restricted access, and high Altmetric scores (which includes lay press and social media citations).[87, 88] Disallowing publication costs could be particularly harmful to ESIs who are trying to make a name for themselves by making their research as broadly and accessibly disseminated as possible. Unlike more senior investigators, ESIs and mid-career scientists would not be able to support publication costs using other sources of funding. Further, publication is a significant part of how someone advances in their scientific career and limitations on funding could have an unintended negative impact on ESIs as it limits ability to publish research, intensifying the wane of the next generation researchers in the United States even further.

To ensure scientific stewardship and decision-making, we require skilled, dedicated, and passionate leaders who are prepared to lead tidal changes in aging. We strongly recommend OMB to prioritize safeguarding the progress and investment our country has made for the health of the American public.

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Thank you for the opportunity to provide these comments. **We believe that OMB should not finalize this rule. We encourage you to provide additional time for public input with the goal of ensuring that our nation is prepared to meet the unique health needs of all Americans as we age**. For additional information or if you have any questions, please do not hesitate to contact Anna Kim at akim@americangeriatrics.org.

Sincerely,

Alison A. Moore, MD, MPH, FACP, AGSF
President

Nancy E. Lundebjerg, MPA
Chief Executive Officer

[87] Piwowar H, Priem J, Larivière V, et al. The state of OA: a large-scale analysis of the prevalence and impact of open access articles. *PeerJ.* 2018;6(e4375):1-23. doi:10.7717/peerj.4375
[88] Clayson PE, Baldwin SA, Larson MJ. The open access advantage for studies of human electrophysiology: impact on citations and Altmetrics. *Int J Psychophysiol*. 2021;164:103-111. doi:10.1016/j.ijpsycho.2021.03.006