Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

July 13, 2026

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

Re: **Proposed Regulation for Federal Financial Assistance (OMB–2026–0034)**

Dear Director Vought:

I am writing on behalf of the Catholic Health Association of the United States (CHA), the national leadership organization representing more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations. Our ministry is present in all 50 states and the District of Columbia, with one in every seven patients in the United States cared for in a Catholic hospital each year.

CHA's mission and ministry, shared by our members, are grounded in the values that drive each of our organizations. Our ethical standards in health care are rooted in the Catholic Church's teachings about the dignity of the human person and the sanctity of human life from conception to natural death. These values are the foundation of our commitment to the moral dimensions of health care. They direct us to insist on accessible and affordable health care for all, to care for the sick and dying, and to serve the common good of our nation and its citizens by caring for all persons regardless of age, race, religion or any other category, in a manner consistent with our consciences. The following comments reflect these principles and our continuing commitment to serving our patients and communities in line with our faith values.

- **Greater Uncertainty and Lack of Transparency in Funding Decisions**

The proposed rule would create greater uncertainty in discretionary funding decisions by requiring review by senior political appointees to consider whether each proposed award aligns with current administration priorities (§ 200.205(b)). While decision making authority does ultimately rest with agency leadership, this proposal would shift the focus away from longstanding merit-based review processes and increase the potential for funding decisions to vary significantly across administrations. Uncertainty about whether peer reviewer, career staff, or subject matter expert recommendations may be overridden could discourage participation in competitive funding opportunities and reduce confidence in the fairness and consistency of the grantmaking process. Weakening this framework could lead to less transparent funding decisions

and divert organizational resources toward navigating shifting policy expectations rather than advancing program goals and outcomes for the communities these programs are intended to serve.

For providers, this uncertainty is especially consequential because federal assistance often supports activities beyond directly reimbursable patient care and requires substantial time and resources to develop proposals, build partnerships, and prepare to implement federally funded activities. CHA members rely on federal support for preparedness and emergency response, rural health care delivery, workforce recruitment and training, behavioral health and crisis services, HIV/AIDS care, and facility updates that help maintain safe environments for patients and staff. If funding decisions become less transparent or more vulnerable to shifting federal priorities, providers may be less able to plan for and sustain services that meet community needs.

CHA urges OMB to reconsider this proposal and to reaffirm the role of subject matter experts and merit-based review in discretionary funding decision making.

- **Expanded Compliance and Oversight Requirements**

We are also concerned that the proposed rule would significantly increase administrative burden through new compliance obligations, documentation requirements, and oversight mechanisms. Recipients already operate within a robust framework of statutory, regulatory, auditing, and reporting requirements designed to ensure accountability for federal funds. The proposed additions, including expanded monitoring requirements (§200.329), new payment justification obligations (§200.305), additional compliance reviews (§200.206(b)(2)), and several new restrictions on allowable activities, would redirect substantial resources from program implementation to administration.

Several proposed restrictions are especially concerning because they rely on broad concepts and undefined standards, while also acknowledging that program-specific statutes may require different approaches. Absent swift and targeted agency guidance, this ambiguity would shift the burden to grant applicants and recipients to try and discern which new regulatory requirements apply to which programs, significantly increasing administrative burden for providers that participate in multiple federal programs with different statutory purposes and compliance frameworks.

For example, providers may need to assess whether and how new restrictions apply to many discretionary and mandatory funding streams that support many different functions and programs, including extramural research grants from the National Institutes of Health, discretionary workforce grants, preparedness funding from the Centers for Disease Control & Prevention (CDC) and the Federal Emergency Management Agency (FEMA), Health Center Program grants from the Health Resources and Services Administration (HRSA), Environmental Protection Agency (EPA) grants for building improvements, Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health grants, Ryan White HIV/AIDS Program

funding, and 988 crisis response funding. Moreover, pass-through entities may take different approaches when interpreting these proposed regulatory restrictions, further increasing the likelihood of inconsistencies and administrative burdens for downstream recipients. The cumulative effect would be higher compliance costs, reduced efficiency, and greater difficulty administering federal programs intended to serve patients and communities.

In addition, while reimbursement for fee-for-service care under Medicaid and Medicare are not affected by the proposed rule, its application to other funding streams is not clear – for example, CMS Innovation Center payment models and the Medicare Rural Hospital Flexibility program as well as certain payments to Medicaid managed care organizations.

CHA requests that OMB reconsider and streamline the expansive and burdensome expanded compliance and oversight requirements, provide clarification about their applicability and explicitly exclude funding streams related to the provision of patient care.

- **Reduced Predictability and Long-Term Funding Stability**

Finally, we are concerned that discretionary agency authority to suspend or terminate discretionary awards would weaken the stability and predictability needed to administer federally funded programs successfully. Many federal initiatives require long-term planning, sustained investments in infrastructure and personnel, and multi-year commitments to individuals, communities, and implementation partners. Although the proposed rule encourages multi-year awards, that objective is undermined by provisions authorizing agencies to suspend (§ 200.340(e)) or terminate (§ 200.340(a)(2)) awards based on changing policy priorities with limited procedural protections for recipients. Providers cannot effectively plan, hire staff, contract with vendors, develop partnerships, or make capital investments when funding may be withdrawn—with minimal notice and no opportunity to appeal— before program objectives are achieved.

CHA notes that OMB's existing regulations (§§ 200.339–200.340) provide ample authority for agencies to suspend or terminate grants based on recipient noncompliance with program requirements or concerns about program integrity. By increasing the possibility that funding decisions may shift across administrations, the proposal risks creating a more volatile federal funding environment that discourages long-term investments and reduces program effectiveness.

Predictable funding is particularly important for non-profit rural hospitals and other safety net providers with no margin to spare. For these providers, it is simply not feasible to maintain large reserves of funds to cover for the possibility of a sudden withdrawal of federal funding. These institutions depend on federal assistance for workforce capacity, facility upgrades, emergency preparedness, behavioral health access, and community partnerships. If funding is withdrawn, patients and communities will suffer.

CHA urges OMB to clarify in the final rule that grant modification or termination must be related to noncompliance, changes in the underlying statute or extraordinary circumstances identified in the final so grant recipients have advance notice.

- **Religious Liberty Concerns**

As a faith-based health care ministry, we very much appreciate the inclusion of protections for faith-based organizations to ensure they are not discriminated against or disfavored when they apply for federal financial assistance. We note that § 200.300(c) appears to be limited to applicants and suggest OMB make clear the protections apply throughout the entire grant process. There are many existing laws that protect liberty, for example the Religious Freedom Restoration Act (RFRA). OMB should acknowledge this in the final rule and make clear that the rule does not displace other statutes or regulations that are more protective of religious liberty.

However, we do have several concerns about the possible negative impacts the rule as proposed could have on the religiously based activities of grant applicants and recipients. The principles of Catholic social doctrine, including the inherent dignity of each person, the common good, and concern for the poor and vulnerable, provide a moral and ethical basis for the Catholic health care ministry. Over the past three centuries, Catholic health care in the United States has focused on bringing hope and healing to all, regardless of sex, race, faith, ethnic background, disability, or any other category or status. Today, this calling and our sacred responsibility to uphold the dignity of every person demands that we uphold the dignity of immigrants, condemn all forms of racism and discrimination, continually strive to eliminate the health disparities when they are present and protect mothers and their babies at all stages of pregnancy.

Provisions regarding immigrants

Section 200.205(2) provides that "[d]iscretionary awards must not be used to fund, promote, encourage, subsidize or facilitate" illegal immigration or initiatives that compromise public safety, and § 200.206 requires risk assessments of grant applicants, including whether the applicant has a history of questionable practices such as affiliation with organizations that undermine public safety. We note that immigration has been characterized by some as a threat to public safety.

Catholic hospitals, health facilities and social service ministries provide basic services for all, regardless of their immigration status, compelled to do so by their faith. The Catholic Church has long prioritized meeting the basic needs of immigrants including food, shelter, health care, transportation and education. Many of these ministries receive federal financial assistance to fund various programs, including programs unrelated to the immigrants they serve. Given the broad and vague language in the proposal, we are concerned that providing basic services to immigrants could be interpreted as facilitating illegal immigration or compromising public safety and prevent or chill the ministries of the Church, including CHA's members, from providing

services that are required by our faith and constitute religious activity protected by the First Amendment and RFRA.

We urge OMB to make clear that providing basic services to immigrants of any legal status will not be considered to be facilitation of illegal immigration or a threat to public safety.

Provisions related to racial discrimination

Section § 200.205(2) also takes a firm stand against racism and racial discrimination, a position CHA shares. Once again, however, the breadth and vagueness of the language is of concern. Federal grants must not be used "to fund, promote, encourage, subsidize or facilitate" where race or proxies are used for program participation. Similar language is used in § 200.300 and applied to all federal awards. The proposed § 200.218 states that award recipients and subrecipients must not "adopt, issue or enforce disparate-impact liability *standards* in administering programs or activities *supported by* a Federal award."

As already stated, our respect for the inherent dignity of every person, based on our Catholic faith, impels us to ensure that people receive the health care they need and to eliminate unwarranted disparities in care. As a result, we are very concerned that, taken together, the proposed language could chill or prevent important work being done by ministries of the Church, as well as public health agencies, secular hospitals, clinics, universities and other federally funded entities to identify and address health disparities in our communities. The disparate impact section's exception for statistical or demographic analyses is limited to internal use only and the results may not be used in connection with activities under a Federal award. This limitation raises uncertainties about whether data identifying the needs of specific communities could be used for targeted outreach in programs connected to a federal grant – to address, for example, the disproportionately high rate of opioid use in certain white communities. As another example, would it prevent programs that reach out to pregnant black mothers, who statistical and demographic data have shown die from pregnancy related causes at a much higher rate than white women?

CHA requests that OMB make clear in the final rule that these kinds of activities may continue even if federal grant money supports some aspect of the program or the entity receives unrelated federal grant funding.

Abortion

The proposed rule would disallow the charging of costs "associated with" elective abortions to federal grants. Catholic health facilities do not perform abortions but Catholic clinics or other ministries of the Church receiving federal grants may be called upon to treat women suffering from complications following an abortion or to provide post-abortion counselling.

CHA urges OMB to clarify that costs related to post-abortion services are not "associated with" elective abortions.

In closing, thank you for the opportunity to provide comments on this rule. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

Lucas Swanepoel, JD
Vice President Public Policy and Advocacy