December 26, 2025

Michael Kratsios
Office of Science and Technology Policy
New Executive Office Building
725 17th Street NW
Washington, DC 20502

Dear Director Kratsios:

AcademyHealth is pleased to provide input to inform the development of federal policy updates that aim to accelerate the American scientific enterprise, enable groundbreaking discoveries, and ensure that scientific progress and technological innovation benefit all Americans.

As the professional home for health services and systems researchers, policy experts, and practitioners, AcademyHealth is dedicated to improving health outcomes for all.
Our more than 2,000 members have deep expertise in the factors that affect the cost, quality, availability, and outcomes of health care and public health, providing balanced, evidence-based information to policymakers and decisionmakers in public and private settings.

We understand that America's scientific enterprise thrives when it is resourced predictably, empowered to translate knowledge into practice, and protected from short-term political or market pressures. Stable, multi-year federal investments are essential to build and maintain research infrastructure, including modern data systems and stewardship capacity that require sustained development, standardization, and governance. For example, advancing federated data architectures, rigorous documentation, and metadata stewardship—critical foundations for timely, policy-relevant science—depend on long-horizon support in funding and incentives structures, not one-off grants.

At the same time, we believe that policy should accelerate innovative models of research that elevate societal impact in funding, evaluation, and recognition—such as programs explicitly organized around translation and community engagement and assessment frameworks that reward demonstrable benefits beyond publications.

Finally, safeguarding the independence and integrity of the scientific community is paramount. AcademyHealth views funding mechanisms reforms and other incentives as a way to strengthen rigor and transparency, broaden participation, and improve the social value of research without compromising the arm's-length decision-making that allows science to pursue truth, take risks, and serve the public good.

In support of this perspective, AcademyHealth is happy to provide responses to Questions v, vi, x, and xii posed in the RFI. These ideas are grounded in rigorous metascientific findings that AcademyHealth has relied on in its efforts to promote more timely health services and policy research that has greater relevance for all Americans and uses the most up-to-date approaches to ensure rigor. Since 2019, we have undertaken initiatives to reimagine the scientific process—and the federal government's role in it—for the field of health services and policy research. In addition to applying techniques like human-centered design first developed in the private sector, the potential innovations we have identified draw on the existing body of metascience knowledge and experience. The corresponding literature underlying our responses is reflected in a series of publications resulting from this effort, in addition to other sources listed in footnotes:

Cassil A., "Using Real-World Data and Artificial Intelligence to Advance Health Services Research," AcademyHealth. June 2021.

Grant, J., "Academic Incentives and Research Impact: Developing Reward and Recognition Systems to Better People's Lives," AcademyHealth. February 2021.

Guthrie, S., "Innovating in the Research Funding Process: Peer Review Alternatives and Adaptations," AcademyHealth. November 2019.

Guthrie, S., "Innovative Funding Models During COVID-19," AcademyHealth. March 2021.

Spitzer-Shohat, S. & M.H. Chin. "Unbounding a Discipline to Bind Innovative Change: A New Paradigm for Health Services Research," AcademyHealth. April 2021.

I. Question v: What empirically grounded findings from metascience research and progress studies could inform Federal grantmaking processes to maximize scientific productivity and increase total return on investment? Please provide specific examples of evidence-based reforms that could improve funding allocation, peer review, or grant evaluation.

Research funding in the United States relies on peer-review processes to ensure quality and rigor. However, a growing body of evidence recognizes the limitations of this approach. For example, the literature shows low agreement among reviewers assessing the same NIH applications, indicating substantial randomness in outcomes and limited predictive validity of fine-grained scoring. Funding agencies may consider refining their processes to acknowledge this uncertainty and safeguard against the biases current approaches can enable.

Additionally, the current grantmaking system often over-rewards novelty and basic science output, which metascience studies suggest may correlate poorly with ultimate patient and public benefit. HSR provides the framework and methods to define ROI as the reduction of suffering, improved quality of care, and cost-effectiveness. AcademyHealth believes in measuring the ROI of health research not just by the generation of knowledge (publications, citations), but by the successful translation of that knowledge into effective policy and practice. Metascience findings

provide an empirical basis to move federal grantmaking away from process metrics and toward measurable societal impact.

Our response focuses on areas where the federal government, particularly through HSR funding agencies like the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH), can apply metascience principles. Maximizing scientific productivity and return on investment (ROI) in health is inextricably linked to evidence utilization and impact on public health outcomes and equity, as demonstrated by our recommendations. NIH and other agencies could consider the following promising policies to maximize scientific productivity and increase total return on investment:

A. **Allocate by lottery.**

Funding agencies may consider conducting an initial streamlined peer review to identify and screen out those projects that clearly lack appropriate rigor and subsequently allocate at least some awards by lottery, especially among proposals of indistinguishable merit or in areas where novelty is hard to assess *ex ante*. Theoretical and practical proposals for lotteries (including focal randomization) are well-articulated and have been trialed internationally. Lotteries result in science that are no less productive scientifically than traditional peer-review approaches and provide a greater opportunity for the "out-of-the-box" thinking that often yields innovative, important advances. The lottery approach also helps democratize the research process by facilitating a broader pool of funded researchers and institutions. Lottery-based approaches are also less administratively burdensome and costly.

B. **Fund people.**

Shifting a portion of funding to investigator- or team-based awards enables sustained, creative research and reduces application churn, as argued by metascience leaders. Productivity is enhanced by allowing researchers to spend more time on science and less on funding applications.

C. **Anonymize and broaden participation in review.**

Traditional peer review is not double-blinded in that the identity of applicants is presented to reviewers. In addition, study sections often draw from a relatively narrow set of established, elite reviewers, which tends to reinforce conventional wisdom about a given area of research. Tests like NSF's "Big Pitch" suggest anonymization can reduce halo effects and speed decisions. Engaging patients and lay stakeholders can improve relevance and trust—though structures must find a balance between valuing equitable participation by non-scientists and ensuring appropriate technical review.

D. **Greater efficiency and broader input through technology and virtual processes**.

Emerging technologies including AI have the potential to make parts of the review process more efficient and draw on more diverse expertise through automation, better matching of reviewers

with proposals, and the use of virtual over in-person convening of review panels. In addition, funding agencies may consider how technology could reduce the burden on applicants.

E. **Prizes and fast grants for time-sensitive or well-defined challenges.**

The need for faster turnaround research during the COVID-19 pandemic spurred a number of funding innovations that resulted in important, timely discoveries. Short application forms, rolling review of proposals, greater internal decision authority funding agencies, and the use of reward incentives demonstrated that accelerated processes could channel funds quickly when speed matters, with lessons applicable to broader federal grantmaking outside of a crisis.

F. **Elevate societal impact as an explicit criterion.**

Metascience has demonstrated that current funding approaches to funding health research correlate poorly with ultimate patient and public benefit. To address this challenge, funding agencies could incorporate potential societal impact alongside scientific merit into their decision-making experimenting with different approaches. In recent years, the NSF's use of "broader impact" criteria value things like impacts of proposed studies on the STEM workforce and infrastructure, public engagement, contributions to national economic competitiveness, national security, partnerships with industry, and social well-being.[1] The UK's Research Excellence Framework (REF),[2] which bases university funding on institutions' scientific track records, is another approach, though changes in the REF over time demonstrate the risk of gaming by universities and the need for continuous learning and refinement of the system.[3]

Incorporating past impacts into funding decisions also require sound strategies for measuring impact. HSR provides the framework and methods to assess improved quality of care, and potential cost-effectiveness of interventions derived from scientific research. In addition, AcademyHealth has engaged in a sustained effort over the last decade to improve the measurement of impact.[4] Further, AcademyHealth encourages review criteria for any applied health research grant to incorporate metrics of implementation success, such as reach, fidelity, and sustainability.

G. Aligning incentives with societal impact.

AcademyHealth believes in grant selection and institutional incentives that reflect societal value, not just academic prestige. Through the implementation of impact-weighted criteria and models that elevate impact in assessment (e.g., PCORI's criteria), federal programs may incorporate

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[1] Renoe, S., et al. "Evolution of Broader Impacts," Center for Advancing Research Impact in Society. 2023. https://researchinsociety.org/wp-content/uploads/2023/08/Evolution-of-Broader-Impacts2023-ARIS.pdf.
[2] Research Excellence Framework. "Initial decisions next steps December 2023," December 2023. https://2029.ref.ac.uk/news/update-on-initial-decisions/.
[3] "PCE Pilot Report," Research Excellence Framework. https://2029.ref.ac.uk/wp-content/uploads/2025/12/PCE-Pilot-Report.pdf.
[4] Weinberg, S. & DeCosta, D. "Measuring and Communicating Impact: How Philanthropy Can Show and Tell its Impact to Rally the Public in Defense of Research." Grant Makers in Health. December 2025.

measures of policy change, practice change, and demonstrated improved health outcomes or cost savings into grant selection and performance review.

H. **Pre-registration and transparency for clinical and applied trials.**

For all federally-funded applied studies and clinical trials, the federal government could require pre-registration of protocols and analysis plans (e.g., via ClinicalTrials.gov or OSF). This is an evidence-based reform proven to reduce researcher bias (e.g., p-hacking and HARKing) and increase the reliability of findings.

I. **Support for replications and meta-research.**

AcademyHealth recommends the government consider dedicated specific funding pools for high-priority replication studies in fields with high public health importance, like behavioral science or public health interventions. Furthermore, agencies could fund meta-research (metascience) to continuously evaluate the efficiency and rigor of federal funding and review processes.

J. Dedicate more funding to ensure the translation of science into real world benefits.

The greatest drag on ROI in health research is the delay and failure in moving evidence-based findings into real-world use—the "valley of death." Metascience supports the need for dedicated funding for dissemination and implementation (D&I) Science. AcademyHealth recommends that federal programs budget funds specifically for D&I efforts within all translational grants, utilizing HSR methods to study what works to move evidence into practice. This budget line may include resources for developing plain-language summaries and technical assistance for adoption.

K. Reform grantmaking to promote rigor, relevance, and high-risk science

The reproducibility crisis erodes public and policymaker trust, destroying research ROI. HSR, which depends on real-world data and policy relevance, requires high-integrity findings. Metascience has provided compelling empirical evidence regarding the failures of reproducibility and the conservative bias in peer review. Reforms in this space address both scientific integrity and the tendency of current systems to favor incremental, "safe" science. The federal government's options include changes like Funder-Led Portfolio Management (utilizing models where a program officer, rather than a panel of peer reviewers, manages a portfolio of diverse, high-risk projects, similar to DARPA or some NIH Common Fund programs) and "Peer Review Lite" for novel ideas (employing concise proposals and rapid review cycles to lower the transactional cost of submitting and reviewing exploratory, early-stage concepts. Examples include NIH Pioneer and New Innovator Awards).

II. Question vi: What reforms will enable the American scientific enterprise to pursue more high-risk, high-reward research that could transform our scientific understanding and unlock new technologies, while sustain the incremental science essential for cumulative production of knowledge?

Several of the ideas outlined in our response to Question v also have the potential to encourage high-risk, high-reward research, including:

- The use of time-bound rapid mechanisms to unlock urgency-driven innovation like those adopted during COVID-19. Examples of policies include brief applications, rolling review, and fast turn-around internal decision-making. COVID-19 demonstrated that funding agencies can accelerate high-payoff work when needed while using conventional review for longer-range, incremental research.
- Prizes for audacious research that can complement grants by attracting unconventional solvers and lowering the risk associated with large funder investments for moonshot problems.
- Set aside programs that use lotteries to make funding decisions among proposals initially cleared for plausibility. This policy would help mitigate study sections' inherent conservatism to protect bold ideas from conventional wisdom and compressed scoring that does not allow funders to effectively distinguish among proposals.

In addition, cross-disciplinary study sections and funding calls can enable innovative approaches to complex problems by reducing the biases inherent in funding science within topical silos and avoid penalizing projects that cross disease areas, theoretical frameworks, or research methods.

III. Question x: How can Federal programs better identify and develop scientific talent across the country, particularly leveraging digital tools and distributed research models to engage researcher outside traditional academic centers?

AcademyHealth believes in broadening the focus of scientific training to incorporate the broad range of institutions where researchers do their work in the twenty-first century, and the full set of skills needed to ensure societal impact. The federal government could adopt the following policies that support this belief:

A. Training in the use of emerging data sources and practice-facing skills.

Federal programs could fund training in real-world data, machine learning, and data stewardship. Policies related to count creation of shared data assets, linkages, and metadata as valued outputs in fellowships and career awards would align with evolving methods and workforce needs. Distributed training consortia can be delivered virtually and in partnership with non-academic employers to prepare researchers for roles across sectors.

B. Mentoring trainees and fostering collaboration that reaches beyond traditional academic centers.

This includes greater use of remote collaboration platforms, which would expand opportunities for researchers at smaller institutions and in rural or underserved areas to participate in national science and build networks.

C. Enabling communities to lead their own research.

Funding community-based organizations (CBOs) to design, manage, and conduct their own research (with support from partners) can enhance the impact of science by leveraging the lived experiences of people and communities—those who are uniquely qualified to develop contextually appropriate solutions. Private research funders have piloted such community-engaged research programs and seen the impact on ROI; especially in resource-limited times, enhanced focus on community-led problem-solving can increase real-world impact.[5]

D. **Creating open, rolling micro-grant and fellowship mechanisms.**

Building on rapid, short-form application models, agencies could offer frequent, small awards with rolling review to lower barriers to entry for emerging investigators and non-traditional teams.

E. **Promoting cross-sector placements and partnerships**.

AcademyHealth recommends that federal agencies support distributed fellowships and sabbaticals with health systems, industry, and government to develop applied skills. Incentives could be aligned so that partnerships and practical outputs are recognized in federal career development programs. These practices could be normalized with changes in academic promotion and tenure criteria requiring academics to regularly spend time at and collaborate with non-academic institutions.

IV. Question xii: What policy mechanisms would ensure that the benefits of federally-funded research—including access to resulting technologies, economic opportunities, and improved quality of life—reach all Americans?

Ensuring federally-funded HSR reaches "all Americans" is fundamentally and irrevocably a question of equity, and scientific productivity, including for health services research, is limited when the research enterprise is concentrated geographically and demographically. As such, AcademyHealth views equity as the primary determinant of ROI. The current system often allows valuable health innovations to diffuse along existing lines of socioeconomic advantage. This phenomenon, often referred to as the "inverse care law," means that people who need the benefits most often receive them last or not at all.[6] The result is that federally-funded science, despite its success in creating breakthroughs, inadvertently exacerbates existing health and economic disparities. Our perspective, grounded in evidence, is that this is not a knowledge gap as much as it is an implementation and policy gap.

To correct this, AcademyHealth recommends that the federal government use its funding and regulatory authority to embed health equity as an explicit measure of success across the entire R&D lifecycle—from basic discovery to clinical reimbursement. These changes may produce results in which the benefits of federally-funded research reach all Americans. We propose many

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[5] Collado, M., et al., "Let Communities Lead Research," Standford Social Innovation Review, Summer 2025.
[6] Fiscella K, Shin P. (2005). The Inverse Care Law Implications for Healthcare of Vulnerable Populations. *J Ambulatory Care Manage.* Vol. 28, No. 4, pp. 304–312.

policy priorities, supported by concrete mechanisms derived from HSR evidence, to ensure equitable diffusion of research benefits.

A. **Embedding community priorities and experiences from agenda setting to review.**

Requiring and resourcing meaningful engagement of patients, caregivers, clinicians, and communities in governance and peer review can improve applicability and trust when done with shared power. AcademyHealth recommends that federal funding calls and evaluation reflect design challenges identified by field leaders, such as connecting to non-traditional audiences and engaging trusted intermediaries.

B. **Aligning incentives and assessments with societal impact.**

Following models that elevate impact in assessment, federal programs could incorporate beneficiaries reached, policy or practice changed, and improved health outcomes into grant selection and performance review. Programs may also encourage institutions to do the same in their promotions and rankings.

C. **Expanding access to enabling infrastructure.**

Federal agencies could partner with the private sector to procure bulk access to datasets and tools for researchers across the country—especially at resource-constrained institutions—to reduce cost barriers and democratize participation in high-impact research. This could include heavy federal investments in secure distributed data access models (e.g., remote data enclaves) to democratize access to high-value federal data assets (e.g., Medicare/Medicaid claims, administrative data). This change may reduce cost barriers and physical infrastructure requirements that currently concentrate research capacity in large, established centers.

D. **Targeted funding for underrepresented institutions.**

Direct funding and mentorship resources toward Minority-Serving Institutions (MSIs) and rural universities to build capacity for HSR. This ensures that the perspectives of researchers who understand local, and often unique, health disparities are integrated into the federal research portfolio.

E. **Cultivation of policy translation skills.**

Fund training grants that explicitly focus on policy analysis and translation skills (e.g., AHRQ and NIH T32 programs). This ensures the next generation of researchers is equipped not just to publish, but to directly engage with policymakers and health system leaders to convert findings into action, thus maximizing ROI on the research workforce itself.

Collectively, these steps could help the federal government maintain a stable, independent, and socially responsive research enterprise—one that accelerates translation, invests in people, and ensures that the fruits of discovery improve lives in every community.

F. Require and fund disparities-focused research design.

AcademyHealth believes that it is necessary for federally-funded health research to move beyond mere documentation of disparities to the creation and testing of solutions tailored for disadvantaged populations. The federal government could implement policies that include the integration of Implementation Science (IS) and Health Equity (HE) criteria. Grant mechanisms (e.g., across NIH, AHRQ) could require proposals to explicitly detail how the innovation will be adapted, tested, and scaled for communities facing structural barriers (e.g., rural, low-income, linguistically diverse). This would require dedicated funding for IS/HE research, utilizing mechanisms such as AHRQ's R18, to study the real-world factors affecting diffusion.

The federal government could also adopt data stratification and public reporting policies. One option is to mandate the systematic collection and public reporting of outcomes data disaggregated by key demographic and social determinants of health (SDOH) factors (e.g., race, ethnicity, socioeconomic status, geography). This transparency, particularly for Phase III trials and large-scale effectiveness studies, is necessary to identify and correct emerging inequitable benefit distribution immediately.

G. Enforce algorithmic and digital health equity.

As technological innovation, especially in Artificial Intelligence (AI) and digital health, becomes a major product of federal research, we believe in policies that safeguard against algorithmic bias. One option is for federal agencies to adopt regulatory "bias audits" for health technology. For instance, the FDA and the Office of the National Coordinator for Health Information Technology (ONC) could establish pre-market and post-market standards requiring innovators to demonstrate that their algorithms perform equally well across diverse patient populations before and after deployment. This evidence base, which may be informed by HSR methods on fairness and transparency, is critical for ensuring that AI-driven clinical decision support tools do not perpetuate systemic racism or under-triage care for specific groups.

H. Reforming payment and financial incentives to drive equity.

The most powerful policy lever for equitable diffusion is through federal payment and purchasing power (Medicare, Medicaid, VA, etc.), ensuring adoption is feasible and profitable in low-resource settings. Because of this, the federal government could adopt equity-adjusted payment models. Traditional fee-for-service payment models prioritize volume over value and often create financial disincentives for serving complex, underserved populations. Federal agencies could implement policy-driven incentives for equitable adoption through explicit, financial incentives for the adoption of evidence-based practices in disparity-reducing ways. This can include “equity bonuses" within value-based payment models that reward health systems not just for achieving an outcome, but for achieving parity in that outcome across their patient populations, as well as higher reimbursement for novel interventions when delivered through care models that include services proven by HSR to overcome access barriers (e.g., telehealth in rural areas, culturally competent care, or community health worker support).

I. Fund the social and digital infrastructure of equity.

Diffusion is blocked when underserved communities lack the foundational resources (technology, workforce, trust) to utilize the innovation. Because of this, federal investment in non-clinical infrastructure is important; directly fund the non-clinical capital necessary for equitable diffusion. This includes dedicated grants to health systems and Federally Qualified Health Centers (FQHCs) for digital connectivity and increased capacity for community engagement. Digital connectivity may include subsidies for hardware, broadband, and technical support needed to use digital health innovations in rural and low-income clinics. Increased community engagement could include dedicated, sustainable funding streams for community health workers and patient navigators—personnel that HSR studies show are essential for building trust and translating complex science into community action.

J. Fostering authentic community and policymaker engagement.

Equitable diffusion hinges on trust and relevance. AcademyHealth believes that the process of developing and applying research must be transparent, bidirectional, and co-created with the communities it aims to benefit. In this aim, the federal government could prioritize community-led research agendas. This would allow research questions to be defined by the needs of the populations most affected by inequities, moving away from a top-down model. One specific policy change could be to expand participatory research models. Federal agencies may expand models like the NIH's Community Partnerships to Advance Science for Society (ComPASS) and PCORI's emphasis on co-creation, ensuring that research funding includes resources for equitable partnerships with community-based organizations (CBOs). Funding would be provided directly to CBOs to ensure their autonomy and capacity to participate as true partners in defining the research and implementing the results.

K. **Requiring and funding robust dissemination and translation plans.**

HSR shows that research diffusion to policy happens through both "big bang" findings and “gradual accumulation".[7] AcademyHealth encourages the federal government to deliberately cultivate the latter. Too often, valuable projects run out of time and resources before findings are translated into accessible language or implemented into practice. This creates a critical bottleneck in equitable diffusion. Federal agencies could change this by formalizing knowledge translation and dissemination by establishing dedicated knowledge transfer roles within key federal policy agencies (e.g., ASPE, CMS, HRSA) staffed by individuals trained in HSR and policy analysis. These roles would actively synthesize accumulated HSR findings into actionable policy briefs, moving beyond a passive "publish and wait" model. Another option would be to dedicate budget and technical assistance for translation. Federal programs must require and provide dedicated budget lines and technical assistance for dissemination and implementation (D&I) support. These plans may specify communication through channels accessible to different

[7] Gold, M. “Pathways to the Use of Health Services Research in Policy,” Health Services Research. August 2009.

audiences (e.g., policy briefs, community presentations, non-English materials) and include a strategy for technical assistance to implement the findings in resource-constrained settings.[8]

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Thank you for the opportunity to discuss the perspectives and concerns of the health services research community. For further comment, clarification, or inquiry, please email Josh Caplan, Director of Government Relations, at Josh.Caplan@AcademyHealth.org.

[8] Dopp, A., et al. "Optimizing Federal Grants to Scale Up Evidence-Based Practices in Health and Social Services: Recommendations from Federal and State Agency Officials," RAND. February 2025.