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POSITION PAPER

Improving the Health of and Access to Health Care for People With Disabilities: A Position Paper From the American College of Physicians

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In the United States, people with disabilities experience disparities in health and health care. Disparities stem from inadequate insurance coverage, physically and culturally inaccessible health care facilities, pervasive harmful misconceptions about disability, and incomprehensive epidemiologic data regarding disability. In this position paper, the American College of Physicians offers recommendations to alleviate health disparities among people with disabilities through policy changes in areas such as health insurance coverage, accessibility of health care facilities, health professional education, research participation, and data collection.

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The World Health Organization conceptualizes disability as a result of the interaction between individuals with various health conditions and environmental factors such as negative attitudes, inaccessible public spaces, and limited social supports (1). Estimates of the number of Americans with any disability from survey data range from 42.5 million to 61 million (2–4). However, these data on disability prevalence have been limited by several factors such as survey methods, exclusion of individuals in long-term care facilities, and questions used to identify disability.

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA) have codified sweeping protections for persons with disabilities in the context of employment, public accommodations, transportation, access to public programs, and services such as health care organizations. After the Supreme Court's narrow interpretation of the definition of disability, Congress enacted the Americans with Disabilities Act Amendments Act of 2008 to broaden the definition and reinstate the scope of protections initially intended under the ADA. Section 1557 of the Patient Protection and Affordable Care Act further expanded protections for people with disabilities when served by health programs or activities that receive federal funding or are administered by the U.S. Department of Health and Human Services (HHS) (5). Yet, despite decades of legal regulations and social progress, people with disabilities still face widespread discrimination and persistent barriers to health care.

Ableism is a set of beliefs or practices that devalue and discriminate against people with disabilities and pervades U.S. society (6). A legacy of this discrimination, as manifested by forced institutionalization and a misconception that disability is inherently a deficit, has contributed to persistent inequities and fostered ableism as normative. In the United States, people with disabilities still face barriers to education, housing, employment, and high-quality health care that result in health disparities beyond those due to their disability. In 2024, the employment rate among people with disabilities was 22.7% compared with 65.5% for those without a disability (7). People with disabilities have lower life expectancy, higher rates of chronic illness, and lower use of preventive care (8, 9). Health disparities among those with disabilities reflect diverse barriers such as institutional discrimination, inaccessible health care facilities, inadequate benefits, restricted health care coverage, and exclusion from clinical trials and research. Health care professionals may also harbor negative stereotypes and have inadequate training in cultural competency and communication with people with disabilities. The American College of Physicians (ACP) recognizes that these challenges pervade the care of people with

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disabilities and that specific changes are necessary to promote patient-centered, culturally appropriate care.

In this paper, "people with disabilities" refers to individuals with any of a wide range of physical, sensory, communication, cognitive, intellectual, learning, and psychiatric disabilities. The authors use person-first language (people with disabilities) throughout the paper, though some instances of identity-first language (disabled people) are used to reflect variance in terminology in the literature. The authors also recognize that people with disabilities reserve the right to refer to themselves with either person-first language or identity-first language based on many factors such as the centrality of disability in one's identity. ACP recognizes the importance of framing disability with the social model, which posits that disability results from societal barriers that hinder an individual from participating in some aspect of society. ACP reaffirms its commitment to achieving optimal health for all, understanding that this may vary for different people, and to addressing health disparities among historically marginalized populations. Although policy changes are needed to promote inclusion for people with disabilities in many aspects of society, such as education and meaningful employment, the ACP policy recommendations focus on improving the accessibility of health care for people with disabilities. Policymakers must address both physical and cultural barriers to high-quality health care. The medical community must also commit to training and educating physicians, at all levels of training and practice, to provide culturally and linguistically appropriate care. ACP acknowledges that people with disabilities also experience underrepresentation in the medical profession. The companion to this paper, "Fostering Support and Inclusion for Physicians, Postgraduate Trainees, and Medical Students With Disabilities," offers recommendations to foster matriculation and support for medical students, postgraduate trainees, and physicians with disabilities (10). That paper also addresses stereotypes about disability, care for patients with disabilities, and fostering a physician workforce that reflects patient diversity.

METHODS

ACP's Health and Public Policy Committee (HPPC) drafted this position paper as part of its role to address issues affecting the health care of the U.S. public and the practice of internal medicine and its subspecialties. The Committee scanned available English-language, peer-reviewed studies, reports, and surveys pertaining to health disparities and access to health care among persons with disabilities, identified by searching PubMed, Google Scholar, and government agency websites, including HHS and the Congressional Research Service. The Committee also searched think-tank and professional websites, including KFF and the Center for American Progress. The inclusion of data-driven sources was prioritized, although opinion and commentary pieces were included to describe the current environment. Given the breadth of the topic, HPPC focused its review on studies related to adult populations cared for by internal medicine physicians. Based on this review, the Committee drafted recommendations with input from ACP's Health Equity Committee, Education Committee, Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Subspecialty Societies, Council of Resident/Fellow Members, and Council of Student Members. The position paper and recommendations were approved by ACP's HPPC on 26 August 2025 and by the Board of Regents on 8 November 2025. The expanded background and rationale can be found in the Appendix (available at Annals.org).

RECOMMENDATIONS

1. *ACP recognizes people with disabilities as a population experiencing health disparities and recommends that policymakers commit to actively combatting ableism and understanding and addressing disparities in health and health care for people with disabilities.*
2. *ACP reaffirms that all people, including people with disabilities, should have access to high-quality and affordable health care and adequate social and living supports.*
3. *ACP supports the designation of people with disabilities as a Special Medically Underserved Population under the Public Health Service Act.*

Training Physicians to Care for Patients With Disabilities

4. *ACP recognizes the importance of training physicians and other health care professionals on providing comprehensive care for patients with a wide range of disabilities and actively combating biases about people with disabilities. ACP urges medical education institutions to develop and implement disability education curriculum.*
5. *ACP encourages implementation of continuing medical education programs focused on the comprehensive care of patients with a wide range of disabilities.*

Accessibility of Health Care Facilities

6. *ACP encourages health care institutions to evaluate and update facilities, medical equipment, and communication practices to ensure they are accessible to people with a range of disabilities. Health care facilities should adopt clear policies for the provision of appropriate accommodations, compliant with applicable state and federal laws, and ensure staff are informed of their legal responsibility to provide care for patients with disabilities.*

Health Insurance Coverage and Long-Term Supports and Services

7. *ACP supports policy changes to ensure Medicare, Medicaid, and other programs provide adequate,*

accessible, and affordable coverage to people with disabilities.

8. *ACP reaffirms its call for policymakers and employers to address shortages in the workforce for the Long-Term Supports and Services sector.*
9. *ACP supports policies to improve care coordination and alignment of benefits for individuals dually eligible for Medicare and Medicaid.*

Research Participation and Data Collection

10. *ACP reaffirms that clinical trials should be inclusive of all populations, including people with disabilities. Clinical trial design should include accommodations necessary to foster such participation.*
11. *ACP encourages increased comprehensive, high-quality, and disaggregated demographic data collection on a wide range of disabilities to empower policymakers and stakeholders to better understand and address health disparities among people with disabilities. Furthermore, ACP calls for increased study of the delivery of care to people with disabilities and the impact of disability-concordant physician–patient relationships on patient satisfaction and health outcomes.*

CONCLUSION

People with disabilities face barriers to health care and health disparities stemming from multiple factors including inadequate health coverage, physically and culturally inaccessible health care facilities, pervasive misconceptions about disability, and incomplete data about this diverse population. Although decades of advocacy by the disability community have prompted important policy changes to increase access in many facets of society, many more actions must be taken to ensure an equitable and inclusive health care system for people with disabilities. As a physician organization whose members serve patients of many backgrounds, ACP believes it is essential to combat ableism and promote culturally and linguistically appropriate, patient-centered health care. ACP continues to advocate for solutions to remove challenges in health care for people with disabilities.

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References

1. **World Health Organization**. Disability. Accessed at www.who.int/health-topics/disability#tab=tab_1 on 4 May 2025.

2. **U.S Census Bureau.** Disability Characteristics. Accessed at https://data.census.gov/table/ACSST1Y2019.S1810?t=Disability&hidePreview=true on 16 December 2024.

3. **ADA National Network**. How Many People in the United States Have a Disability? Accessed at https://adata.org/faq/how-many-people-united-states-have-disability on 16 December 2024.

4. **Centers for Disease Control and Prevention**. Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults. Accessed at www.cdc.gov/disability-and-health/articles-documents/disabilities-health-care-access.html?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/features/kf-adult-prevalence-disabilities.html on 16 December 2024.

5. Patient Protection and Affordable Care Act. Protecting Individuals Against Sex Discrimination. Nondiscrimination. §1557(a), 42 USC §18116(a) (2018).

6. **Center for Disability Rights**. #Ableism. Accessed at https://cdrnys.org/blog/uncategorized/ableism on 16 December 2024.

7. **U.S. Department of Labor Bureau of Labor Statistics**. Persons with a Disability: Labor Force Characteristics – 2024. Accessed at www.bls.gov/news.release/pdf/disabl.pdf on 4 May 2025.

8. **Mitra M, Long-Belil L, Moura I, et al.** Advancing health equity and reducing health disparities for people with disabilities in the United States. Health Aff (Millwood). 2022;41:1379-1386. [PMID: 36190894] doi:10.1377/hlthaff.2022.00499

9. **Marrocco A, Krouse HJ.** Obstacles to preventive care for individuals with disability: implications for nurse practitioners. J Am Assoc Nurse Pract. 2017;29:282-293. [PMID: 28266148] doi:10.1002/2327-6924.12449

10. **Cline K, Beachy MW, Carr PW, et al; Health and Public Policy Committee of the American College of Physicians.** Fostering support and inclusion for physicians, postgraduate trainees, and medical students with disabilities: a position paper from the American College of Physicians. Ann Intern Med. 10 March 2026. [Epub ahead of print]. doi:10.7326/ANNALS-25-04518

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Appendix: Background And Rationale

Demographics and Disparities

Disabilities vary widely and occur across all ages, genders, sexual orientations, and racial, ethnic, and social groups. Disability prevalence increases with age. Data from 5 federal surveys show substantially higher rates of disability among adults older than 65 years compared with younger and working-age adults, but most people with disabilities are younger than 65 years (8). Among racial and ethnic groups, the highest age-adjusted disability prevalence has been reported for American Indian/Alaska Native populations (8). Black, Latinx, and Native Hawaiian/Pacific Islander populations have slightly higher age-adjusted prevalences of disability than White and Asian populations (8). Overall disability prevalence is higher among women compared with men, whereas transgender and gender-nonconforming individuals have higher prevalence compared with cisgender individuals (11, 12). Lesbian and bisexual adults also report higher disability prevalence compared with their heterosexual counterparts (13). Disability prevalence is increased for justice-involved individuals; in 1 national study, 38% of individuals incarcerated in state and federal prisons had at least 1 disability (14).

Adults with disabilities are 4 times more likely to report fair or poor health than adults without disabilities (8). Their overall risk for mortality is 1.9 times higher than that of nondisabled adults (15). People with disabilities also report having more comorbidities; they are 3 times more likely to report having arthritis, diabetes, and heart disease and 5 times more likely to report stroke and depression compared with nondisabled people (16).

Intersections of disability and other sociodemographic characteristics can amplify disparities. Among people with disabilities, those in historically marginalized racial and ethnic groups report worse health outcomes compared with non-Hispanic White individuals and compared with persons without disabilities in the same racial and ethnic groups (17). Pregnant people with disabilities are more likely to delay prenatal care and have a higher risk for preterm birth and/or low birthweight (18).

The COVID-19 pandemic exacerbated health-related challenges faced by people with disabilities. In this population, restrictions on available routine health care services, difficulty interpreting information, and fear of infection led to underutilization of health care services, and, consequently, negative effects on health and well-being (19). People with disabilities were approximately 50% more likely to report delaying medical care during the COVID-19 pandemic than those without a disability (20). Furthermore, the enactment of crisis standards of care, standards intended to guide the allocation of resources in times of pervasive or catastrophic disaster, explicitly discriminated against people with disabilities in care rationing in many jurisdictions and health systems (21). People with disabilities in long-term care facilities during the COVID-19 pandemic experienced shortages of personal protective equipment, inadequate staffing, and inability to isolate in communal living space. In the early months of the pandemic, from 40% to 49% of COVID-19 deaths occurred in long-term care facilities (22).

Designation as a Population Experiencing Disparities

In the past, failure to designate people with disabilities as a population experiencing health disparities and barriers to care contributed to limited research and national interventions to address challenges. However, progress has been made recently. In September 2023, the National Institute on Minority Health and Health Disparities designated people with disabilities as a population experiencing health disparities (23). This designation created funding opportunities for National Institutes of Health (NIH)-funded research to address the impact of disability, along with sociodemographic risk factors, on health care access and health outcomes (16).

The U.S. Department of Health and Human Services (HHS) first designated people with disabilities as a population experiencing disparities in 2000 in its Healthy People 2010 report. The most recent iteration of the Healthy People initiative, Healthy People 2030, defined 18 objectives to improve the health of people with disabilities in areas such as increasing access to community-based living and education, improving survey methods to obtain demographic data, and reducing cost-related delays in preventive care (24). Since 2020, HHS has reported improvements in only 2 of these goals, whereas 2 have worsened. Moreover, the failure of HHS to designate people with disabilities as medically underserved prevents additional resources from being dedicated to reducing their disparities in care. The HEADs UP Act of 2023 sought to authorize HHS to designate people with developmental disabilities as a health-professional shortage population so that clinicians serving these individuals could become eligible for National Health Service Corps scholarships and student loan repayment programs (25).

Health Professional Education

Health care for people with disabilities has been compromised by deficient physician education about disability and the unique issues facing this population. There are no core competencies related to disability education in medical schools, so it varies widely across institutions. Although not specific to people with disabilities, Section 5307 of the Patient Protection and Affordable Care Act (ACA) authorized HHS to fund the development and dissemination of model curricula for cultural competency, public health proficiency, and reducing health disparities but unfortunately did not mandate implementation (26). Stillman and colleagues reported that only 35% of internal medicine and family medicine residents received disability-specific education during medical school, whereas nearly all respondents expressed interest in receiving more training (27). A survey of practicing U.S. physicians found that only 41% of respondents reported being "very confident" about providing a similar quality of care to people with disabilities compared with those without (28). Only slightly more than half of the physician respondents strongly agreed that they welcomed people with disabilities into their practice. Kakara and Aysola reported that patients with a disability perceived not being treated with respect and/or not receiving understandable health-related information during health care visits (29). Woodard and colleagues reported that negative attitudes and stigma toward people with disabilities largely reflected poor training (30). Underrepresentation of people with disabilities among medical students, physicians, and other health care professionals may also contribute to a lack of understanding, exposure to disability, and cultural competency in provision of care.

Accessibility of Health Care Facilities

Hospitals and medical practices are classified as "businesses that are open to the public" and must meet specific requirements to provide people with disabilities an equal opportunity to access services, but this should not represent an "undue hardship" for the institution. Failure to recognize this obligation or provide a reasonable alternative has led to people with disabilities being discharged from some practices (31). Most physician participants in a 2020 interview study demonstrated an incorrect or superficial understanding of their legal responsibilities to accommodate and care for people with disabilities (32).

The passage of the Americans with Disabilities Act of 1990 (ADA) and subsequent rulemaking have improved care for people with disabilities. Regulations finalized in 2024 amended Section 1557 of the ACA to require covered programs to train all employees on procedures for language access, effective communication, and reasonable modifications, thus shifting the responsibility to the health care system rather than the clinician (33). One survey of physician attitudes about disability found that all participants reported physical barriers to providing health care for people with disabilities, including both building structures and medical equipment (31). That survey revealed that physicians whose offices did not have an accessible scale sent patients in a wheelchair to a supermarket, a grain elevator, or a cattle-processing plant to be weighed (31). Regulations that took effect in 2024 require all newly purchased or otherwise acquired medical diagnostic equipment to comply with the U.S. Access Board's standards for medical diagnostic equipment. The standards set requirements for height accessibility and compatibility with portable patient lifts and wheelchairs (34, 35). They also require instructions or other information about diagnostic procedures to be provided in at least 2 ways (audible, visible, or tactile). Health care facilities must have at least 10% of all medical diagnostic equipment units—but no fewer than 1—that meet these standards.

Health care facilities' accessibility involves effective communication and reasonable accommodations to ensure that people with disabilities have equal access. Section 4302 of the ACA requires health care organizations to document patients' disabilities, and, since 2014, this must be included among patient demographic characteristics in the electronic health record. Despite these policies, accommodation questions may exclude some disabilities, and these data are often not consistently collected (36). Physicians have expressed concerns about the expense of these accommodations and insufficient reimbursement for their effort and practice resources (31).

Health Insurance Coverage

In 2023, an estimated 21% of people with disabilities of all ages were covered only by Medicaid, 15% by both Medicaid and Medicare, 34% by Medicare, and 26% by employer or other private coverage (37). The passage of the ACA allowed many people with disabilities to gain private coverage for the first time by prohibiting insurers from denying coverage based on an individual's preexisting conditions. Between 2010 and 2018, the proportion of uninsured adults with a disability decreased from 46% to between 9% and 17%, reflecting increased private coverage eligibility and Medicaid expansion (38). Despite this major increase in coverage rates, in 2023, 51% of people with disabilities experienced delays in primary and periodic preventive care due to costs (39).

Medicare covers 9.1 million people with disabilities under age 65 years, representing 12% of all Medicare beneficiaries (40). Many people with disabilities are eligible for Medicare and/or Medicaid through Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). The Social Security Administration restricts eligibility for these programs to individuals who cannot engage in any "substantial gainful activity" because of a disability that is expected to result in death or last for at least 12 months (41). These eligibility criteria make SSI and SSDI inaccessible to many people with disabilities who do not fit the agency's narrow definition of disability. The complex and fragmented nature of federal coverage programs also hinders many people with disabilities who may be eligible for benefits from receiving them. Barriers include extensive time and effort in navigating the system and compiling and completing necessary paperwork and physical barriers in accessing in-person offices and appointments (42).

More than 10 million people nationwide qualify for Medicaid because of disability (43). Although many of these individuals are dually eligible for Medicare and Medicaid, an estimated 6.2 million are only enrolled in Medicaid. Dual eligibles comprise 17% and 14% of beneficiaries in traditional Medicare and Medicaid, respectively, but account for 33% and 32% of total spending (44). In 2022, dual-eligible special needs plans, which are private Medicare Advantage plans that exclusively enroll beneficiaries with Medicaid, were available in 46 states and enrolled 4.1 million individuals. High expenditures on this population are in part due to their complex conditions as well as the lack of coordination and alignment of dual eligibles covered by separate Medicare and Medicaid plans. Nonelderly dual-eligible people with disabilities face challenges with finding clinicians who accept Medicare and Medicaid, long wait times, poor access to specialists and/or personal caregivers, and barriers to social determinants of health such as food, transportation, and housing costs (45). The Financial Alignment Initiative was launched by the Centers for Medicare & Medicaid Services (CMS) to offer benefits in a single joint Medicare–Medicaid plan through a 3-way contract between the state, federal government, and health plan. Evaluations of the program have shown mixed results in spending, enrollment, and beneficiary experience, so CMS plans to transition these plans to dual-eligible special needs plans (46). People with disabilities insured in narrow clinician (or "provider") networks are especially likely to have unmet health care needs, although federal law requires that Medicaid network adequacy standards ensure physical access to clinicians, ADA-compliant accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with disabilities (47, 48).

Working people with disabilities whose income and/or assets exceed limits for other eligibility pathways can buy in to Medicaid coverage. Buy-in programs in many states charge premiums starting at varied income levels, and most have eligibility caps on income and assets (49). These caps can force persons with disabilities to choose between working more or losing their coverage; advocates note that these caps can discourage couples from marrying or pressure them to separate if both partners are disabled (50). Asset limits in Medicaid and other federal support systems further hinder people with disabilities from building savings and exercising financial autonomy (51). Enrollment in buy-in programs has been reportedly low nationwide, at least partially due to a lack of awareness of these programs (50). ACP's paper "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care" offers broader recommendations to address fragmentation in coverage and achieve universal health care (52).

On 2 July 2025, the One Big Beautiful Bill Act of 2025 (OBBBA) was signed into law. The Congressional Budget Office predicts provisions of the OBBBA will result in an estimated $1 trillion reduction in federal spending due to changes to Medicaid and the Health Insurance Marketplace (53). The OBBBA is additionally expected to increase the number of uninsured individuals by 10 million by 2034, with three quarters of the coverage losses attributable to spending cuts to Medicaid and the Children's Health Insurance Program (53). Changes to Medicaid include new burdensome administrative requirements for enrollment, restrictions on eligibility such as work requirements, and restrictions on funding mechanisms used by states to finance their share of Medicaid costs. The OBBBA exempts individuals who are "medically frail" from work requirements, though burdensome documentation is required to verify disability, which will ultimately result in coverage losses (54). Overall, the changes to Medicaid in the OBBBA pose a serious threat to millions of people with disabilities who rely on Medicaid for coverage (55).

Long-Term Services and Supports

Long-term services and supports (LTSSs) offer varied health and health-related services to individuals who lack the capacity for independent self-care for an extended period of time (56). Assisting people with activities of daily living to maintain or improve quality of life and functioning, LTSSs are delivered in institutional settings, such as nursing homes, or in the community, through home- and community-based supports (HCBSs). An estimated 6 million individuals receive Medicaid LTSSs, of whom more than two thirds are under age 65 years and qualify for Medicaid because of a disability (57). As the primary payer for LTSSs, Medicaid expended $207.0 billion in 2021, which accounted for one third of all Medicaid personal health care spending (58).

Studies report that HCBSs are more cost-effective than institutional care, and people with disabilities prefer community integration to maintain independence and a connection to their families, friends, and communities (59). The 1999 landmark Supreme Court case *Olmstead v L.C.* decreed that people with disabilities have a qualified right to receive state-funded supports and services in the community rather than institutions if appropriate (60). Despite this ruling, Medicaid programs are only required to provide coverage for institutional care and home health services while other HCBSs are optional with coverage varying widely by state. Coverage for HCBSs is typically delivered through 1915(c) waivers, and all states offer at least 1 such waiver. In 2018, 2.5 million individuals received HCBSs through Section 1915(c) or 1115 Demonstration waivers (61). Yet the supply does not meet demand. Medicaid HCBS waiver waitlists totaled nearly 820 000 people nationally, with wait times of 39 months (62). People with intellectual or developmental disabilities comprised 73% of the total waitlist population (63).

Uncompensated family caregivers are the primary providers of LTSSs in the United States. In 2019, an estimated 53 million adults in the United States provided unpaid care, and at least 19% of recipients of unpaid care were under age 65 years (64). Many state Medicaid programs offer some support for family caregivers. Under Medicaid 1915(j) waivers, states can pay for self-directed personal assistance services, including relatives who provide LTSSs. Most paid LTSS is delivered by direct care workers (DCWs), including certified nursing assistants, home health aides, caregivers, and companions who provide home care services. The United States faces a shortage of DCWs, exacerbated by the COVID-19 pandemic, an aging population, and federal actions that threaten working immigrants who comprise a third of the home care workforce (65). The National Center for Health Workforce Analysis projects that the demand for DCWs will increase by 48% for nursing assistants, 43% for personal care aides, and 42% for home health aides between 2020 and 2035 (66). In April 2024, CMS finalized a rule that includes new requirements related to

DCWs and access to HCBSs that require at least 80% of all Medicaid payments for specific HCBS home health aide and personal care services to be spent on compensation for DCWs beginning in 2030 (67). This requirement marks an important step toward increasing access to HCBS and personal care services by ensuring funding is spent on wages to promote a robust DCW workforce.

Research Participation and Data Collection

The unjustified exclusion of people with disabilities from clinical research prevents people with disabilities from receiving preventive or therapeutic advances that are not otherwise available and threatens the generalizability and relevance of research findings. For example, individuals with Down syndrome have a high prevalence of Alzheimer disease (70% to 90%), but of hundreds of interventional clinical trials, fewer than 10 were conducted with this population (68). Of 97 interventional study protocols across 4 therapeutic areas, a review reported that 85% permitted investigators to exclude participants at their discretion. Only 18% of reviewed protocols explicitly permitted use of supports or accommodations to facilitate participation, whereas most justifications for excluding people with disabilities were lacking, ambiguous, or unnecessary if accommodations had been provided (69). Participation in research may also be compromised by concerns that some people with disabilities may not be able to provide informed consent or may be subject to undue influence by investigators or other individuals. People with disabilities in guardianship arrangements have additional barriers to participation in research (70).

Limited availability of consistently collected and comprehensive data on people with disabilities has hindered efforts to monitor and improve their health care. Various agencies and researchers use different methods to identify disabilities, which limits comparison and aggregation of results. Section 4302 of the ACA required HHS to create standards for federal data collection and reporting on 5 demographic characteristics: ethnicity, race, sex, primary language, and disability status. Six disability questions from the American Community Survey (ACS), collectively known as the ACS-6, were selected as the standard, and many federal surveys now use the ACS-6. Although this mandate has improved data collection, disability advocates question the inclusiveness of ACS-6 questions because they miss subgroups of people with disabilities. In 2023, the U.S. Census Bureau proposed changing the ACS-6 to the Washington Group Short Set (WG-SS) questions, which offer a continuum of responses instead of the dichotomous ACS-6 questions used in the 2025 census. Due to concerns raised by disability advocates that only persons who report "a lot of difficulty" in response to 1 WG-SS question would be considered a person with disability, excluding those who report "some difficulty," the Census Bureau decided to abandon the change (71). Broader and more inclusive data collection and research are still needed for research, policy making, and program planning to meet the needs of people with disabilities.

Policy Recommendations

1. *ACP recognizes people with disabilities as a population experiencing health disparities and recommends that policymakers commit to actively combatting ableism and understanding and addressing disparities in health and health care for people with disabilities.*
2. *ACP reaffirms that all people, including people with disabilities, should have access to high-quality and affordable health care and adequate social and living supports.*
3. *ACP supports the designation of people with disabilities as a Special Medically Underserved Population under the Public Health Service Act.*

Over the past several years, ACP has developed comprehensive policy frameworks to support populations experiencing health disparities, including racial and ethnic minority populations, individuals experiencing homelessness, indigenous and rural communities, and lesbian, gay, bisexual, transgender, and queer populations (72–76). To advance the goal of improving health equity and access to high-quality health care for all people, ACP recognizes people with disabilities as a population experiencing disparities and calls on policymakers to address their disparities in health and health care.

ACP encourages legislation to designate people with disabilities as a Special Medically Underserved Population (SMUP) to offer additional resources to help address health disparities. For the Health Resources and Services Administration (HRSA) to designate a group as a SMUP when not based on geographic location, Congress must approve it through the Public Health Service Act; this has been done for other SMUP groups including public housing residents, migrant agricultural workers, and unhoused persons. The National Council on Disability (NCD) recommends SMUP designation to bring about wide-ranging benefits such as scholarship or loan repayment programs for clinicians caring for the population, higher CMS reimbursement for serving this population, and federal funding for community health centers (16). Increased reimbursement from CMS will promote access to health care, as many physicians have cited the cost and practice expense of caring for people with disabilities as a hindrance to providing needed high-quality care (31).

Training Physicians to Care for Patients with Disabilities

4. *ACP recognizes the importance of training physicians and other health care professionals on providing comprehensive care for patients with a wide range of disabilities and actively combating biases about people with disabilities. ACP urges medical education institutions to develop and implement disability education curriculum.*
5. *ACP encourages implementation of continuing medical education programs focused on the comprehensive care of patients with a wide range of disabilities.*

More comprehensive disability education should be integrated into medical education and training to improve care and promote inclusion for people with disabilities. In

2019, the Alliance for Disability in Health Care Education published a report outlining 6 core competencies and 49 subcompetencies to offer a basic level of care for patients with disabilities (77). In a 2022 framework, the NCD described this curriculum as central to alleviating health disparities and recommended adoption of these core competencies along with 2 more competencies (16). The NCD highlighted the need for effective, sensitive, and ongoing communication, and acquisition of active-listening skills and nonverbal symbolism to ensure more comprehensive care for patients with disabilities. The curriculum should also offer opportunities for students and trainees to encounter patients and practicing physicians with disabilities in formal training sessions and provide opportunities for elective rotations in health care facilities specializing in the care of people with disabilities.

ACP supports the implementation of disability-related medical school and continuing medical education curricula to ensure physicians have the skills and training to effectively care for people with disabilities and remain up to date on best practices. A 2023 review by Ali and colleagues found notable improvement in medical students' ability to communicate with people with disabilities after disability curricula education in varied formats such as presentations, guest lectures, workshops, and seminars (78). The authors also report that disability-focused curricula positively influenced medical students' perceptions about people with disabilities and increased their understanding of the broader difficulties they face. The implementation of a comprehensive disability module during the primary care clerkship for third-year students at 1 medical school improved knowledge, attitudes, and comfort in caring for people with disabilities (30). That study also emphasized the importance of teaching students that the objective is not to "fix" disability but is instead to appreciate a patient's functional status and address associated secondary concerns (30).

Accessibility of Health Care Facilities

6. *ACP encourages health care institutions to evaluate and update facilities, medical equipment, and communication practices to ensure they are accessible to people with a range of disabilities. Health care facilities should adopt clear policies for the provision of appropriate accommodations, compliant with applicable state and federal laws, and ensure staff are informed of their legal responsibility to provide care for patients with disabilities.*

ACP encourages health care facilities to evaluate cultural, communication, and structural barriers to care for people with disabilities. To address cultural and communication accessibility, it is necessary to ensure available interpreters, braille signage for people who are blind or have low vision, and health-related materials in multiple formats. For physical accessibility, facilities should provide wheelchair-accessible routes from parking or bus stops into buildings, doors with adequate clearance, and appropriate restroom facilities. To assist in financing updates to meet accessibility requirements, tax deductions may be available for some practices, including the Disabled Access Credit for small businesses and the federal Tax Deduction to Remove Architectural and Transportation Barriers to People with Disabilities and Elderly Individuals (79).

To provide adequate accommodations to people with disabilities, health care facilities should develop standardized methods to gather information about a patient's needed accommodations before an appointment. Questions about needed accommodations should capture a broad range of disabilities, and this information should be collected consistently in electronic health records, even when a disability may not be apparent.

Health Insurance Coverage and Long-Term Supports and Services

7. *ACP supports policy changes to ensure Medicare, Medicaid, and other programs provide adequate, accessible, and affordable coverage to people with disabilities.*
8. *ACP reaffirms its call for policymakers and employers to address shortages in the workforce for the Long-Term Supports and Services sector.*

To increase insurance coverage for people with disabilities, ACP supports eliminating asset and income caps for people with disabilities in Medicaid buy-in programs, increased funding and regulatory changes to expand HCBSs covered by Medicaid and other programs, and physician reimbursement that adequately compensates for the cost of caring for patients with complex and/or multiple disabilities. Furthermore, ACP supports robust federal funding for Medicaid programs and opposes policy changes that would result in vulnerable populations losing Medicaid eligibility. The removal of income and asset caps for people with disabilities in Medicaid buy-in programs will help people with disabilities who wish to work so that they will not need to choose between gainful employment, accumulating savings and assets, and maintaining health coverage. Several states, such as Massachusetts and Tennessee, have eliminated income and asset caps for people with disabilities in their buy-in programs and instead charge premiums on a sliding scale proportional to income. Congress should amend Section 1557 of the ACA to remove asset and resource limits for Medicaid buy-in programs nationally. The NCD has called for clear and accessible consumer information and resources for buy-in programs to increase awareness by people with disabilities (51). Furthermore, reimbursement through Medicaid and Medicare is essential in ensuring people with disabilities, especially those with complex care needs, have access to comprehensive health care.

ACP calls on policymakers to address workforce shortages in the LTSS sector through comprehensive training, pay increases, benefit packages, and opportunities for career advancement. ACP reaffirms its support for policies to support unpaid caregivers through compensation and training. During the COVID-19 pandemic, 45 states used public health emergency authorities to increase Medicaid payment rates to HCBS providers and 33 of these states made the increased payments permanent after the public health emergency (80). Furthermore, 17 states made permanent changes to allow family members or friends to be paid providers. A rule finalized in 2024 requires states to ensure a minimum of 80% of Medicaid payments for home health aide and personal care services be spent on compensation for DCWs, marking an important step in supporting the workforce (67). Comprehensive training should include education on and exposure to patients with disabilities.

9. *ACP supports policies to improve care coordination and alignment of benefits for individuals dually eligible for Medicare and Medicaid*.

Integrated comprehensive care for the dual-eligible population requires coordination of services and payments as well as alignment of administrative procedures. The Medicare Payment Advisory Commission (MedPAC) recommended limiting how often dual-eligible persons can change plans and expanding passive enrollment, which would automatically enroll beneficiaries in a coordinated plan unless they choose to opt out (81). The Medicaid and CHIP Payment and Access Commission (MACPAC) recommends that Congress authorize HHS to require each state to develop an integrated care strategy for full-benefit dual-eligible beneficiaries and provide additional funding to support states in developing these strategies (82). They also suggested the development of a unified program specifically for the dual-eligible population to simplify benefits currently provided by both Medicare and Medicaid under 1 single program. Policies to improve coverage should also ensure clinician networks are adequate so that dually eligible beneficiaries have access to disability-competent clinicians.

Research Participation and Data Collection

10. *ACP reaffirms that clinical trials should be inclusive of all populations, including people with disabilities. Clinical trial design should include accommodations necessary to foster such participation.*

11 *ACP encourages increased comprehensive, high-quality, and disaggregated demographic data collection on a wide range of disabilities to empower policymakers and stakeholders to better understand and address health disparities among people with disabilities. Furthermore, ACP calls for increased study of the delivery of care to people with disabilities and the impact of disability-concordant physician–patient relationships on patient satisfaction and health outcomes.*

ACP has called for clinical trials to be inclusive of all populations, including systematically marginalized people, pregnant and lactating people, children, and older people, to ensure that all people have equitable access to scientific innovation (83). ACP reaffirms this commitment to people with disabilities. Protocols for clinical trials should offer explicit accommodations for people with disabilities throughout the research program. DeCormier Plosky and colleagues caution investigators against using phrasing that excludes large groups of people, such as "people who can't travel to all appointments" (69). ACP supports the work of the NIH Disability Health Research Coordinating Committee in developing a strategic plan for disability research (84).

ACP supports efforts to increase the inclusivity and harmonization of disability-related data collection encompassing a full range of disabilities. The disability community should be engaged in developing questions for data collection. High-quality data disaggregated by demographic characteristics such as race and ethnicity will facilitate examining intersectional patterns and impacts. A recent evidence review and report to Congress by the Agency for Healthcare Research and Quality (AHRQ) described 3 guiding principles to inform research on barriers to preventive health services to people with disabilities. The AHRQ emphasized meaningful engagement with disability communities throughout the research process, building trust between researchers and people with disabilities, and recognizing diversity among people with disabilities (85). The AHRQ report recommended research at the health care system level, focusing on care delivered by clinical teams for people with disabilities. Research should also explore ways to improve the transition from pediatric to adult care of people with disabilities.

Research suggests that racially and ethnically concordant physician–patient relationships can enhance communication and overall satisfaction with care, but this model of care has not been adequately examined for people with disabilities (86). Therefore, ACP recommends research on disability-concordant physician–patient relationships.

Web References

11. **Centers for Disease Control and Prevention**. Disability and Health Data Systems: United States, DC and Territories – Category: Disability Estimates. Accessed at www.cdc.gov/dhds/about/index.html on 16 December 2024.

12. **Varadaraj V, Deal JA, Campanile J, et al.** National prevalence of disability and disability types among adults in the US, 2019. JAMA Netw Open. 2021;4:e2130358. [PMID: 34673966] doi:10.1001/jamanetworkopen.2021.30358

13. **Fredriksen-Goldsen K, Kim H, Barkan S.** Disability among lesbian, gay, and bisexual adults: disparities in prevalence and risk. Am J Public Health. 2012;102:e16-e21. [PMID: 22095356] doi:10.2105/AJPH.2011.300379

14. **Maruschak LM, Bronson J, Alper M.** Disabilities Reported by Prisoners. U.S Department of Justice Bureau of Justice Statistics; March 2021. Accessed at https://bjs.ojp.gov/content/pub/pdf/drpspi16st.pdf on 6 May 2025.

15. **Landes SD.** Disability mortality disparity: risk of mortality for disabled adults nearly twice that for nondisabled adults, 2008-19. Health Aff (Millwood). 2024;43:1128-1136. [PMID: 39102592] doi:10.1377/hlthaff.2023.01197

16. **National Council on Disability**. Health Equity Framework for People with Disabilities. February 2022. Accessed at www.ncd.gov/assets/uploads/reports/2022/ncd_health_equity_framework.pdf on 16 December 2024.

17. **Magaña S, Parish S, Morales MA, et al.** Racial and ethnic health disparities among people with intellectual and developmental disabilities. Intellect Dev Disabil. 2016;54:161-172. [PMID: 27268472] doi:10.1352/1934-9556-54.3.161

18. **Horner-Johnson W, Dissanayake M, Marshall N, et al.** Perinatal health risks and outcomes among US women with self-reported disability, 2011–19. Health Aff (Millwood). 2022;41:1477-1485. [PMID: 36130140] doi:10.1377/hlthaff.2022.00497

19. **Hunt X, Hameed S, Tetali S, et al.** Impacts of the COVID-19 pandemic on access to healthcare among people with disabilities: evidence from six low- and middle-income countries. Int J Equity

Health. 2023;22:172. [PMID: 37653417] doi:10.1186/s12939-023-01989-1

20. **Akobirshoev I, Vetter M, Iezzoni L, et al.** Delayed medical care and unmet care needs due to the COVID-19 pandemic among adults with disabilities in the US. Health Aff (Millwood). 2022;41:1505-1512. [PMID: 36190876] doi:10.1377/hlthaff.2022.00509

21. **Bagenstos SR**. Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols. The Yale Law Journal; 27 May 2020. Accessed at www.yalelawjournal.org/forum/who-gets-the-ventilator#_ftnref15 on 16 February 2025.

22. **Chidambaram P**. Key Questions About the Impact of Coronavirus on Long-Term Care Facilities Over Time. KFF; 1 September 2020. Accessed at www.kff.org/report-section/key-questions-about-the-impact-of-coronavirus-on-long-term-care-facilities-over-time-issue-brief on 16 December 2024.

23. **National Institutes of Health**. NIH designates people with disabilities as a population with health disparities. 26 September 2023. Accessed at www.nih.gov/news-events/news-releases/nih-designates-people-disabilities-population-health-disparities on 6 May 2025.

24. **Healthy People 2030**. People With Disabilities. U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. Accessed at https://health.gov/healthypeople/objectives-and-data/browse-objectives/people-disabilities on 16 December 2024.

25. HEADs UP Act of 2023, HR 3380, 118th Congress (2023-2024). Accessed at www.congress.gov/bill/118th-congress/house-bill/3380/text on 16 December 2024.

26. The Public Health and Welfare, Grants for Health Professions Education, 42 USCA §293e.

27. **Stillman M, Ankam N, Mallow M, et al.** A survey of internal and family medicine residents: assessment of disability-specific education and knowledge. Disabil Health J. 2021;14:101011. [PMID: 33041247] doi:10.1016/j.dhjo.2020.101011

28. **Iezzoni LI, Rao SR, Ressalam J, et al.** Physicians' perceptions of people with disability and their health care. Health Aff (Millwood). 2021;40:297-306. [PMID: 33523739] doi:10.1377/hlthaff.2020.01452

29. **Kakara M, Aysola J.** Perceptions of culturally responsive care among people with disabilities. Ann Intern Med. 2025;178:602-604. [PMID: 40030180] doi:10.7326/ANNALS-24-01964

30. **Woodard LJ, Havercamp SM, Zwygart KK, et al.** An innovative clerkship module focused on patients with disabilities. Acad Med. 2012;87:537-542. [PMID: 22361803] doi:10.1097/ACM.0b013e318248ed0a

31. **Lagu T, Haywood C, Reimold K, et al.** 'I am not the doctor for you': physicians' attitudes about caring for people with disabilities. Health Aff (Millwood). 2022;41:1387-1395. [PMID: 36190896] doi:10.1377/hlthaff.2022.00475

32. **Agaronnik ND, Pendo E, Campbell EG, et al.** Knowledge of practicing physicians about their legal obligations when caring for patients with disability. Health Aff (Millwood). 2019;38:545-553. [PMID: 30933590] doi:10.1377/hlthaff.2018.05060

33. **U.S. Department of Health and Human Services**. Public Welfare, Training, 45 CFR 92.9. Accessed at www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-92/subpart-A/section-92.9 on 16 December 2024.

34. U.S. Department of Health and Human Services. Nondiscrimination on the basis of disability in programs or activities receiving federal financial assistance. Fed Regist. 2024;89:40066-40195.

35. **U.S. Access Board**. Medical Diagnostic Equipment Accessibility Standards. Accessed at www.access-board.gov/mde/chapter-m3/#m301-diagnostic-equipment-used-by-patients-in-supine-prone-or-side-lying-position on 14 January 2025.

36. **Morris MA, Hamer MK, Eberle K, et al.** Implementation of collection of patients' disability status by centralized scheduling. Jt Comm J Qual Patient Saf. 2021;47:627-636. [PMID: 34144917] doi:10.1016/j.jcjq.2021.05.007

37. **Burns A**, **Cervantes S**. 5 Key Facts About Medicaid Coverage for People with Disabilities. KFF; 7 February 2025. Accessed at www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-disabilities on 23 November 2025.

38. **Creedon TB, Lamont H, Dey J, et al**. Health Insurance Coverage Among Working-Age Adults with Disabilities: 2010-2018. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation; 30 July 2021. Accessed at https://aspe.hhs.gov/reports/health-insurance-coverage-among-working-age-adults-disabilities-2010-2018 on 16 December 2024.

39. **Healthy People 2030**. Reduce the proportion of adults with disabilities who delay preventive care because of cost. U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, Accessed at https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/people-disabilities/reduce-proportion-adults-disabilities-who-delay-preventive-care-because-cost-dh-01#cit2 on 15 December 2024.

40. **Koma JW, Biniek JF, Cubanski J, et al.** Access problems and cost concerns of younger Medicare beneficiaries exceeded those of older beneficiaries in 2019. Health Aff (Millwood). 2023;42:470-478. [PMID: 37011311] doi:10.1377/hlthaff.2022.00501

41. **Social Security Administration**. How Do We Define Disability? Accessed at www.ssa.gov/redbook/eng/definedisability.htm?tl=0 on 16 February 2025.

42. **Schweitzer J, DiMatteo E, Buffie N, et al**. How Dehumanizing Administrative Burdens Harm Disabled People. Center for American Progress; 5 December 2022. Accessed at www.americanprogress.org/article/how-dehumanizing-administrative-burdens-harm-disabled-people on 15 December 2024.

43. **Medicaid and CHIP Payment and Access Commission (MACPAC)**. People with disabilities. 30 July 2025. Accessed at www.macpac.gov/subtopic/people-with-disabilities/#:~:text=Other%20eligibility%20pathways,Special%20income%20level on 21 November 2025.

44. **Peña MT, Mohamed M, Burns A, et al**. A Profile of Medicare-Medicaid Enrollees (Dual Eligibles). KFF; 31 January 2023. Accessed at www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles on 16 February 2025.

45. **Lyons B, Andrews J**. Improving Medicare–Medicaid Integration: Priorities of Dual-Eligible Adults Under Age 65. The Commonwealth Fund; 26 February 2025. Accessed at www.commonwealthfund.org/publications/issue-briefs/2025/feb/improving-medicare-medicaid-integration-dual-eligible-under-65 on 1 April 2025.

46. **Peña MT, Mohamed M, Burns A**. Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals. KFF; 27 April 2023. Accessed at www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals on 1 April 2025.

47. Network adequacy standards. 42 CFR §438.68.

48. **Hughes PM, Wu BS, Annis EI, et al.** Association of inadequate provider networks with unmet need for health services and self-employment among people with disabilities. J Health Care Poor Underserved. 2022;33:984-997. [PMID: 35574889] doi:10.1353/hpu.2022.0076

49. **KFF**. Medicaid Eligibility through Buy-In Programs for Working People with Disabilities. 2025. Accessed at www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D on 1 April 2025.

50. **Leys T**. Many People With Disabilities Risk Losing Their Medicaid if They Work Too Much. KFF Health News; 25 March 2025. Accessed at https://kffhealthnews.org/news/article/medicaid-disabilities-work-asset-caps-buyin-premiums-rural-iowa-legislation/?utm_campaign=KHN%3A%20First%20Edition&utm_medium=email&_hsenc=p2ANqtz–SbofoDv6teQQqc4eMLd_z6ZLRd_W526plnrFvWzw-

DLoDe1akARA_m781gtg-Sw4i1gZyfAvIqV1KJ8LcjPrAoC90MQw&_hsmi=353431491&utm_content=353431491&utm_source=hs_email on 1 April 2025.

51. **National Council on Disability**. 2023 Progress Report: Toward Economic Security: The Impact of Income and Asset Limits on People with Disabilities. 31 October 2023. Accessed at www.ncd.gov/report/2023-progress-report-toward-economic-security-the-impact-of-income-and-asset-limits-on-people-with-disabilities on 1 April 2025.

52. **Crowley R, Daniel H, Cooney TG, et al; Health and Public Policy Committee of the American College of Physicians.** Envisioning a better U.S. health care system for all: coverage and cost of care. Ann Intern Med. 2020;172:S7-S32. [PMID: 31958805] doi:10.7326/M19-2415

53. **Park E**. New CBO Health Coverage Estimates of Budget Reconciliation Law. Georgetown University McCourt School of Public Policy; 14 August 2025. Accessed at https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law on 21 November 2025.

54. An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, HR 1, 119th Congress (2025), Public Law No. 119–21. Accessed at www.congress.gov/119/plaws/publ21/PLAW-119publ21.pdf on 21 November 2025.

55. **Ives-Rublee M, Musheno K**. The Truth About the One Big Beautiful Bill Act's Cuts to Medicaid and Medicare. The Center for American Progress; 3 July 2025. Accessed at www.americanprogress.org/article/the-truth-about-the-one-big-beautiful-bill-acts-cuts-to-medicaid-and-medicare on 17 December 2025.

56. **Colello KJ**. Long-Term Services and Supports: History of Federal Policy and Programs. Congressional Research Service; 20 December 2023. Accessed at www.congress.gov/crs-product/R47881 on 18 February 2025.

57. **Chidambaram P, Burns A, Rudowitz R**. Who Uses Medicaid Long-Term Services and Supports. KFF. 14 December 2023. Accessed at www.kff.org/medicaid/who-uses-medicaid-long-term-services-and-supports on 16 January 2025.

58. **Colello KJ, Sorenson I**. Who Pays for Long-Term Supports and Services? Congressional Research Service; 19 September 2023. Accessed at https://crsreports.congress.gov/product/pdf/IF/IF10343#:∼:text=19%20pandemic%20assistance.-,Medicaid,44.3%25%20of%20all%20LTSS%20expenditures on 1 April 2025.

59. **U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee**. Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act. 18 July 2013. Accessed at www.disabilityintegrationact.org/wp-content/uploads/2017/07/Olmstead-Report-July-18-2013.pdf on 17 February 2025.

60. *Olmstead v. L. C.,* 527 U.S. 581 (1999).

61. **Watts MO, Musumeci M, Chidambaram P**. Medicaid Home and Community-Based Services Enrollment and Spending. KFF; 4 February 2020. Accessed at www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending on 1 April 2025.

62. **Musumeci M, Watts MO, Chidambaram P**. Key State Policy Choices About Medicaid Home and Community-Based Services. KFF; 4 February 2020. Accessed at www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services on 26 February 2025.

63. **Burns A, Wolk A, Watts MO, et al**. A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024. KFF; 31 October 2024. Accessed at www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024 on 26 February 2025.

64. **AARP, National Alliance for Caregiving**. Caregiving in the United States 2020. 14 May 2020. Accessed at www.aarp.org/pri/topics/ltss/family-caregiving/caregiving-in-the-united-states on 6 February 2025.

65. **Chidambaram P, Pillai D**. What Role Do Immigrants Play in The Direct Long-Term Care Workforce? KFF; 2 April 2025. Accessed at www.kff.org/medicaid/what-role-do-immigrants-play-in-the-direct-long-term-care-workforce/#:∼:text=Immigrants%20make%20up%2028%25%20of,themselves%20and%20their%20loved%20ones on 17 December 2025.

66. **Connacher C**. Direct Care Worker Pay and Benefits Are Low Despite High Demand for Services. Center for American Progress; 8 December 2023. Accessed at www.americanprogress.org/article/direct-care-worker-pay-and-benefits-are-low-despite-high-demand-for-services on 26 February 2025.

67. **Centers for Medicare & Medicaid Services**. Ensuring Access to Medicaid Services Final Rule (CMS-2442-F). Accessed at www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-final-rule-cms-2442-f on 26 February 2025.

68. **Alldred MJ, Martini AC, Patterson D, et al.** Aging with Down syndrome-where are we now and where are we going? J Clin Med. 2021;10:4687. [PMID: 34682809] doi:10.3390/jcm10204687

69. **DeCormier Plosky W, Ne'eman A, Silverman BC, et al.** Excluding people with disabilities from clinical research: eligibility criteria lack clarity and justification. Health Aff (Millwood). 2022;41:1423-1432. [PMID: 36190895] doi:10.1377/hlthaff.2022.00520

70. **National Institutes of Health**. Research Involving Individuals with Questionable Capacity to Consent. National Institutes of Health. November 2009; Updated 13 August 2024. Accessed at https://grants.nih.gov/policy-and-compliance/policy-topics/human-subjects/policies-and-regulations/vulnerable-populations/questionable-capacity on 5 May 2025.

71. **National Council on Disability**. NCD Letter to Census on proposed change to disability questions in American Community Survey. 19 December 2023. Accessed at www.ncd.gov/letters/2023-12-19-ncd-letter-to-census-on-proposed-change-to-disability-questions-in-american-community-survey on 26 February 2025.

72. **Serchen J, Doherty R, Atiq O, et al; Health and Public Policy Committee of the American College of Physicians.** A comprehensive policy framework to understand and address disparities and discrimination in health and health care: a policy paper from the American College of Physicians. Ann Intern Med. 2021;174:529-532. [PMID: 33428444] doi:10.7326/M20-7219

73. **Serchen J, Hilden DR, Beachy MW; Health and Public Policy Committee of the American College of Physicians.** Meeting the health and social needs of America's unhoused and housing-unstable populations: a position paper from the American College of Physicians. Ann Intern Med. 2024;177:514-517. [PMID: 38408358] doi:10.7326/M23-2795

74. **Serchen J, Mathew S, Hilden D, et al; Health and Public Policy Committee of the American College of Physicians.** Supporting the health and well-being of indigenous communities: a position paper from the American College of Physicians. Ann Intern Med. 2022;175:1594-1597. [PMID: 36215716] doi:10.7326/M22-1891

75. **Serchen J, Johnson D, Cline K, et al; Health and Public Policy Committee and the Medical Practice and Quality Committee of the American College of Physicians.** Improving health and health care in rural communities: a position paper from the American College of Physicians. Ann Intern Med. 2025;178:701-704. [PMID: 40163886] doi:10.7326/ANNALS-24-03577

76. **Serchen J, Hilden DR, Beachy MW; Health and Public Policy Committee of the American College of Physicians.** Lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority health disparities: a position paper from the American College of Physicians. Ann Intern Med. 2024;177:1099-1103. [PMID: 38914001] doi:10.7326/M24-0636

77. **Alliance for Disability in Health Care Education**. Core Competencies on Disability for Health Care Education. June 2019. Accessed at https://nisonger.osu.edu/wp-content/uploads/2019/08/post-consensus-Core-Competencies-on-Disability_8.5.19.pdf on 13 January 2025.

78. **Ali A, Nguyen J, Dennett L, et al.** A scoping review for designing a disability curriculum and its impact for medical students. Can Med Educ J. 2023;14:75-86. [PMID: 37465749] doi:10.36834/cmej.74411

79. **Centers for Medicare & Medicaid Services**. Increasing the Physical Accessibility of Health Care Facilities. May 2017. Accessed at www.cms.gov/sites/default/files/repo-new/23/Issue-Brief-Increasing-the-Physical-Accessibility-of-Health-Care-Facilities.pdf on 6 January 2025.

80. **Burns A, Mohamed M, Watts MO**. Pandemic-Era Changes to Medicaid Home- and Community-Based Services (HCBS): A Closer Look at Family Caregiver Policies. KFF; 19 September 2023. Accessed at www.kff.org/medicaid/issue-brief/pandemic-era-changes-to-medicaid-home-and-community-based-services-hcbs-a-closer-look-at-family-caregiver-policies/#:~:text=The%20most%20common%20changes%20included,providers%20(37%20states)%2C%20increasing on 1 April 2025.

81. **Medicare Payment Advisory Commission (MedPAC)**. Letter Re: Congressional Request for Information on Dual-Eligible Beneficiaries. 13 January 2023. Accessed at www.medpac.gov/wp-content/uploads/2023/01/01132023_DualEligibles_RFI_MedPAC_Comment_SEC_v2.pdf on 1 April 2025.

82. **Medicaid and CHIP Payment and Access Commission (MACPAC)**. Letter Re: Request for information on data and recommendations to improve care for dually eligible beneficiaries. Accessed at www.macpac.gov/wp-content/uploads/2024/01/Comment-letter_Congressional-RFI-on-duals_Final.pdf on 1 April 2025.

83. **Serchen J, Cline K, Mathew S, et al; Health and Public Policy Committee of the American College of Physicians.** Preparing for future pandemics and public health emergencies: an American College of Physicians policy position paper. Ann Intern Med. 2023;176:1240-1244. [PMID: 37487216] doi:10.7326/M23-0768

84. **National Institutes of Health Disability Health Research Program.** Disability Health Research Coordinating Committee. Accessed at https://dpcpsi.nih.gov/disabilityhealthresearch/dhrcc on 5 May 2025.

85. **Weinick RM, Sessums LL, Boicourt RM**. Research to Improve the Delivery of Clinical Preventive Services to People with Disabilities. Agency for Healthcare Research and Quality; August 2024.

86. **Iezzoni LI.** Why increasing numbers of physicians with disability could improve care for patients with disability. AMA J Ethics. 2016;18:1041-1049. [PMID: 27780029] doi:10.1001/journalofethics.2016.18.10.msoc2-1610