February 23, 2026

Steven Posnack, Principal Deputy Assistant Secretary for Technology Policy
Office of the Deputy Secretary and Assistant Secretary for Technology Policy (ASTP)
Office of the National Coordinator for Health Information Technology (ONC)
Department of Health and Human Services

Consortium for Constituents with Disabilities
Re: "HHS Health Sector AI RFI," RIN 0955-AA13.

Dear Steven Posnack,

On behalf of the undersigned members of the Consortium for Constituents with Disabilities (CCD) Health Task Force, we submit these comments in response to the Department's Request for Information about Artificial Intelligence.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance. The Health Task Force works to ensure access to high quality, accessible, affordable health care for people with disabilities and complex conditions of all ages that meets their individual needs and enables them to be healthy, live as independently as possible, and participate in the community.

We write primarily to respond to Question #10: *"What challenges within health care do patients and caregivers wish to see addressed by the adoption and use of AI in clinical care? Equally, what concerns do patients and caregivers have related to the adoption and use of AI in clinical care?"*

People with disabilities and their caregivers have significant concerns about the adoption and use of AI in clinical care. These concerns include a lack of transparency that make it hard or impossible to understand the basis for treatment reductions or denials, or even whether technology is being used, inadequate testing and auditing of the data and algorithms that drive AI decisions, and the absence of meaningful federal regulation and oversight. We urge the Department to review and consider the growing body of research and lived experience which shows that AI poses serious risks of harm, especially to people with disabilities. HHS must prioritize protecting people by carefully collecting, analyzing, and publicly sharing disaggregated data from all developers and deployers and by evaluating long-term patient outcomes before rapidly deploying new technology. HHS should not sacrifice these essential safeguards for health and safety for the sake of administrative convenience and speed.

AI does not present novel legal or implementation challenges with respect to existing civil rights laws like Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act (incorporating Title VI, Title IX, and The Age Discrimination Act of 1975). These laws and rights all still apply to various aspects of healthcare. Merely incorporating AI into how decisions are made does not insulate that decision or its impact from civil rights enforcement. Neither the government nor the public can rely solely on developers/deployers to police themselves and 3rd party vendors through their hired auditors or their own employees. Oversight using existing laws must be strengthened to ensure that the Federal government's embrace of the promise of AI works to the benefit of its people, rather than causing harm. Populations protected by civil rights laws must be reassured that civil rights enforcement entities will fully investigate and pursue claims of AI bias, and be provided sufficient resources and expertise to do so. Significant information and expertise imbalance means that protected groups cannot be expected to have complete information to fully establish bias, therefore civil rights enforcement agencies must be prepared to investigate claims using existing frameworks.

Rather than employ an untested federal framework, HHS should recognize states' efforts to protect their state populations from AI bias in healthcare, and work in collaboration to develop and test meaningful remedies that fully protect people with disabilities in these high-stakes health care settings.

Benefits of AI for Disabled People Must Be Weighed Against Harms

Many people with disabilities depend on assistive technologies (AT) to navigate daily life and access their communities, including clinical care. These tools improve accessibility, particularly by supporting communication and making information easier to access and share.[1] However, despite their benefits, when AT and other tools employ AI, they introduce real risk for people with disabilities, particularly in clinical care settings without sufficient safeguards against error and bias.[2]

[1] These technologies can take many forms, including apps, software, and hardware created specifically for people with disabilities… In its response to the U.S. Access Board's invitation for public comment on disability and AI, the Administration for Community Living (ACL) wrote, for example, that some of its grantees have integrated artificial intelligence to develop enhanced communication technologies for people who are D/deaf or hard of hearing as well as assistive technologies for children and adults with development disabilities who are learning language and literacy. Similarly, in its public comment, the Perkins School for the Blind noted that AI can help to enhance communication for individuals who are blind, low vision, or deafblind, including via integration in "speech-to-text software, screen readers, and real-time captions. Ctr. for Democracy & Tech. and Am. Ass'n of People with Disabilities, *Building a Disability-Inclusive AI Ecosystem: A Cross-Disability, Cross-Systems Analysis of Best Practices* (Mar. 11, 2025), https://cdt.org/wp-content/uploads/2025/03/2025-03-11-CDT-Building-A-Disability-Inclusive-AI-Ecosystem-report-final.pdf.

[2] For example, "AI-enabled captioning… can be significantly less accurate than captioning done by a human being, due to mistakes as well as outright hallucinations. These technologies could also inadvertently perpetuate ableism by introducing even more inaccuracy for certain types of speakers, such as those with speech differences or who speak with an accent associated with a specific ethnic group." *Id.*

These risks are especially alarming in health settings, where records contain highly sensitive and disability-related information that beneficiaries must often disclose to access benefits and receive care. For example, AI can help patients get support remotely and communicate with providers more easily, which helps people with disabilities to access care and remain in their homes and communities. At the same time, these tools are often error-ridden and raise major privacy concerns.

Even the use of AI in so-called simple administrative tasks like processing paperwork or filing out records can lead to harm. For example, an AI tool that transcribed nearly 7 million medical visits had a known history of making up content in medical transcripts and records.[3] Payers then use these sometimes faulty transcripts and records to make decisions about care.[4] Some provider offices ask patients to allow their AI-generated data to be shared with for-profit companies, including vendors developing these tools, and incorrect outcomes may train algorithms and compound future errors.[5] And while AI may reduce paperwork and delays, it can also cause serious harm when it overrides or interferes with individualized clinical judgment.

Without strong guardrails and transparency requirements, these benefits rarely justify the risks. Yet, HHS has not publicly analyzed, or even acknowledged this body of research and, instead, skews drastically and dangerously toward deregulation.

AI Use in Clinical Settings Creates High Risk of Harm for People with Disabilities

The American Association of People with Disabilities (AAPD) and the Center for Democracy and Technology put it best when they explained why disabled people face a uniquely high risk of harm when interacting with AI tools:

> First, many AI and algorithmic tools are trained on pattern recognition, and make determinations based upon typical patterns within any particular dataset. However, many disabled people (by virtue of their disability) exist outside of typical patterns… Second, AI and algorithmic technologies create outputs based on inputs, which are again derived from datasets. Oftentimes these datasets are

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[3] Garance Burke & Hilke Schellmann, *Researchers Say an AI-Powered Transcription Tool Used in Hospitals Invents Things No One Ever Said*, Associated Press (Oct. 26, 2024), https://apnews.com/article/ai-artificial-intelligence-health-business-90020cdf5fa16c79ca2e5b6c4c9bbb14.

[4] Once an error is documented, patient records are extremely difficult to correct. Even where a patient gets transcripts to review, for example, and has the chance to correct the record for one doctor, it is really hard to correct misinformation across the system (from different providers, pharmacies, payer databases), especially without transparency requirements related to where issues are most likely to occur (e.g., an AI transcription error that was not caught). Georgette A. Samaritan, *Correcting Errors in the Electronic Medical Record*, RISK Rx, Vol. 11 No. 1 (2014), https://flbog.sip.ufl.edu/risk-rx-article/correcting-errors-in-the-electronic-medical-record/. One doctor explained that "[e]ven if I, as a physician, catch the error and document a correction, that original record already has been sent to numerous other healthcare providers who won't receive my correction. It becomes like a dangerous game of telephone – the error spreads throughout the healthcare network, and each iteration makes it more difficult to trace and correct." Bill Siwicki, *The Damage AI Hallucinations Can Do - and How to Avoid Them*, Healthcare IT News, (July 24, 2025), https://www.healthcareitnews.com/news/damage-ai-hallucinations-can-do-and-how-avoid-them

[5] *Id.*

> not properly inclusive of people with disabilities – they may have inaccurate data about disability, undersample or improperly tag information as being related to disability… And third, many people with disabilities are multiply-marginalized, meaning that they are both disabled and identify as members of another marginalized group. Many AI and algorithmic tools have been shown to pose unique risks to other marginalized groups as well, meaning that multiply-marginalized disabled people are at a particular risk of facing discriminatory outcomes as a result of their interaction with these tools.[6]

When AI or algorithmic tools make mistakes, the consequences for people with disabilities can be serious and long-lasting. Currently, 73 million low-income people are exposed to AI decision-making in Medicaid through eligibility and enrollment, authorization for home- and community-based services (HCBS), or prior authorization for other medically necessary services. The use of AI in these processes are subject to minimal or no federal oversight.[7] An incorrect denial or delay of services can mean losing access to needed HCBS that help people live independently. For example, one AI tool wrongly "drastically reduced or even removed outright" in-home care hours due to "faulty algorithms."[8] The loss of these services, even for a short time, can force people into congregate care or other institutional settings if AI outputs fail to recommend the sufficient community supports.

Other especially problematic AI tools (or algorithmic tools that AI could expand) for people with disabilities are those that determine the level of care someone gets in a hospital, or even crisis standards of care.[9] Others decide which care is medically necessary based on past claims data. These types of AI tools "may take pre-existing conditions or disability-specific characteristics into account when making their determinations."[10] Alternatively, tools use measures that are often correlated with disabilities or other marginalized identities, like race. For example, the New York Times found an AI tool that uses how many physicians a person sees and how many pharmacies they visit as proxies for addiction risk.[11] High users of care are also correlated with people who have a disability or a chronic condition, so the tool flagged

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[6] Ctr. for Democracy & Tech. and Am. Ass'n of People with Disabilities, *supra* note 1. As one example, people with Intellectual and Developmental Disabilities are largely underrepresented in clinical research. See Dimitri Christakis & Douglas S. Diekema, *Promoting Health Equity for People with Intellectual and Developmental Disabilities Through Research*, JAMA Internal Medicine (2026), https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2844093.

[7] Kevin De Liban, *Inescapable AI: The Ways AI Decides How Low-Income People Work, Live, Learn and Survive*, TechTonic Justice (Nov. 24), https://www.techtonicjustice.org/reports/inescapable-ai.

[8] Lydia X.Z. Brown et. al., *Challenging the Use of Algorithm-Driven Decision-Making In Benefits Determinations Affecting People with Disabilities* (Oct. 2020), https://cdt.org/insights/report-challenging-the-use-of-algorithm-driven-decision-making-in-benefits-determinations-affecting-people-with-disabilities/.

[9] *See, e.g.*, Ari Ne'eman et al., *The Treatment of Disability under Crisis Standards of Care: An Empirical and Normative Analysis of Change over Time During COVID-19*, 46 J. Health Pol. Pol'y & L. 831 (2021), https://doi.org/10.1215/03616878-9156005.

[10] Ctr. for Democracy & Tech. and Am. Ass'n of People with Disabilities, *supra* note 1.

[11] Maia Szalavitz, *Say Hello to Your Addiction Risk Score - Courtesy of the Tech Industry*, New York Times (April 20, 2024) https://www.nytimes.com/2024/04/20/opinion/addiction-risk-score-avertd-narxcare.html

people with disabilities at higher risk of addiction, forcing them and their providers to face burdensome additional barriers to get treatment. Another algorithm used prior health care expenses as a proxy for health care needs, and as a result, Black patients were systematically under-identified for high-risk care management because Black patients historically incur lower health care costs due to systemic barriers to access.[12] Without auditing or correcting for these biases, people with disabilities are at risk of losing access to care.

Racial and disability discrimination is well-documented across AI tools in health care settings.[13] AI systems not only reflect this existing bias, they amplify it at significant speed and scale while making it harder to identify. In one case, because an algorithm used cost as a proxy for health, Black patients were systematically under-identified for high-risk care management because the tool associated higher health care costs with sicker patients.[14] Other documented cases of harm and bias include biased transplant prioritization, unsafe clinical recommendations, and chatbot agents providing inaccurate medical advice.[15] Further, because developers often train AI systems from high-resource hospitals or large datasets of beneficiaries across payer type, the tools frequently underrepresent Medicaid beneficiaries, people with complex or long-term conditions, and people with disabilities.[16]

In addition to overarching issues of training, underlying biased data, and AI hallucination, there is a fundamental issue of whether AI tools are directly accessible to use by and for people with disabilities. Adding AI to a healthcare tool that is already

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[12] "Although these two variables are correlated—sicker patients generally need more care—disparities in health care access… mean that on average African American patients have lower medical costs at the same level of health as Caucasian patients." Ziad Obermeyer at al., *Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations*, 366 Science 447 (2019).

[13] Tipton K, Leas BF, Flores E, et al. *Impact of Healthcare Algorithms on Racial and Ethnic Disparities in Health and Healthcare. Comparative Effectiveness Review No. 268*. (Prepared by the ECRI-Penn Medicine Evidence-based Practice Center under Contract No. 75Q80120D00002.) AHRQ Publication No. 24-EHC004. Rockville, MD: Agency for Healthcare Research and Quality; December 2023. DOI: https://doi.org/10.23970/AHRQEPCCER268 or https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/cer-268-racial-disparities-health-healthcare-addendum.pdf; Patrick Tighe et al., *Artificial Intelligence and Patient Safety: Promise and Challenges*, PSNet, Agency for Healthcare Research & Quality (2024); Kerstin Denecke et al., *Artificial Intelligence and Patient Safety: Promise and Challenges*, PSNet, Agency for Healthcare Research & Quality (2024); Aziz Sheikh et al., *Artificial Intelligence and Health Inequities*, 52 Lancet Reg'l Health-Eur. (2024). For more examples of discrimination, including against people with disabilities, *see* Elizabeth Edwards, David Machledt, Skyler Rosellini & Liz McCaman Taylor**,** *Comments in Response to the AHRQ Request for Information on the Use of Clinical Algorithms That Have the Potential to Introduce Racial/Ethnic Bias into Health Care Delivery* (June 10, 2021) (on file with Nat'l Health Law Program), https://healthlaw.org/resource/nhelp-ahrq-comments/

[14] "Although these two variables are correlated—sicker patients generally need more care—disparities in health care access… mean that on average African American patients have lower medical costs at the same level of health as Caucasian patients." Ziad Obermeyer at al., *Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations*, 366 Science 447 (2019).

[15] Kerstin Denecke et al., *Artificial Intelligence and Patient Safety: Promise and Challenges*, PSNet, Agency for Healthcare Research & Quality (2024).

[16] U.S. Gov't Accountability Off., *Artificial Intelligence in Health Care: Benefits and Challenges of Machine Learning Technologies for Medical Diagnostics*, GAO-21-7SP.

commonly accessible will not advance that tool's accessibility. Telehealth that is not accessible to Deaf persons because information must be exchanged orally, that relies on monitoring or patient data inputs that a Blind person cannot functionally perform, or that requires levels of broadband that are still unavailable in many rural or lower income areas are all barriers that AI does not address. Adding AI home health monitoring devices in conjunction with that, such as offering wearables that assume a patient has a standard body shape, dexterity, or vision, places effective telehealth options even more out of reach of some disabled people. AI transcription tools that fail to capture what people with speech-related disabilities say and that are used to provide information or online interactions are similarly rarely tested for these accessibility issues. In-patient or clinical contexts may use AI monitoring tools that rely on facial recognition or other biometric markers to trigger a health facility's awareness of heightened levels of pain or a return to consciousness will not serve people who have experienced burns with resulting facial scars or limited facial or other mobility, Blind people or Autistic people who have atypical eye movements, or who have medical conditions or are taking medications that affect their heart rate, blood pressure, or breathing rates.

Flawed and Biased Data Scales Harm for People with Disabilities

Beyond issues with bias, many AI tools in health care rely on flawed, incomplete, or poorly designed data. Research has shown that AI tools invent information, misstate citations, rely on retracted research, and misrepresent medical data.[17] When developers train AI systems on faulty or missing data, those tools can misfire at scale, leading to delayed or denied services across entire groups. Large datasets do not fix these problems. Instead, the size and complexity of AI often hides bias, missing context, and systemic errors from human review.[18] These failures fall hardest on people with disabilities, especially those who also hold other marginalized identities.

Data fragmentation across the health care system further undermines AI reliability. Longstanding issues identified by the Government Accountability Office, including inconsistent data standards, weak enforcement of interoperability requirements, and high costs to implement systems, continue to prevent consistent information sharing across the system.[19] Health records are also siloed across electronic health records (EHR), pharmacy platforms, and payer databases, which use incompatible formats.[20] Even within the same hospital system, inconsistent EHR standards produce disjointed records. Additionally, many providers that serve people with disabilities are less likely to use fully integrated EHR systems, like HCBS providers/caregivers, as well as specialty

[17] Am. Med. Assoc., AMA Principles for Augmented Intelligence Development, Deployment, and Use (Nov. 12, 2024), https://www.ama-assn.org/system/files/ama-ai-principles.pdf; Rami Hatem, Briana Simmons, Joseph Thornton, Chatbot Confabulations Are Not Hallucinations, JAMA Intern. Med. 183(19):1177 (2023), doi:10.1001/jamainternmed.2023.4231.
[18] Kun-Hsing Yu et al., *Artificial Intelligence in Healthcare*, 2 Nat. Biomed. Eng'g 719 (2018).
[19] *Id.*
[20] U.S. Gov't Accountability Off., *Artificial Intelligence in Health Care: Benefits and Challenges of Machine Learning Technologies for Medical Diagnostics*, GAO-21-7SP, at 21 (2020).

behavioral health providers.[21] Although CMS interoperability rules address some of these interoperability shortcomings, they will not be fully implemented until at least 2027.[22] Until interoperability is achieved, digital systems will continue to have gaps.

Even when systems adequately share information, AI tools typically rely on "structured" information that leaves out critical context relevant to disability and lived experience. Structured data often excludes information about social determinants of health and other community-based social supports that people with disabilities rely on. Yet these supports, such as stable housing, the receipt of personal care assistance, transportation and mobility, and employment opportunities deeply intertwine with a person's physical and mental health. This can distort care needs and the assessment of a person's level of health, and increase the risk of inappropriate denials. Similarly, AI tools that fail to account both for a disabled patient's reasonable accommodation or policy modification needs miss critical information, including whether the patient actually received the needed accommodation. An AI tool trained to link certain conditions with poor morbidity or mortality outcomes, without accounting for whether a patient was examined on accessible equipment or given more time to communicate their symptoms due to a speech disability operates without data about interventions that may disrupt the presumed causal link between condition and outcome. This mirrors the error identified in the *Obermeyer* study [fn. #14], where AI incorrectly decided that Black patients required less case management because it failed to account for discriminatory under-spending on Black patients.

Private companies often control access to the underlying data, which limits transparency and makes independent testing, validation, or correcting bias nearly impossible. And, despite thousands of studies focused on AI performance, researchers have produced very little, if any, evidence about clinical efficacy and real patient outcomes.[23]

At the same time, AI-assisted utilization management has coincided with increases in care denials, especially in prior authorization.[24] Importantly, not a single study has "compared rates of denials or wrongful denials (those reversed on appeal) in reviews with and without AI, making it difficult to disentangle potential causes of rising denial rates or assess the impacts of AI use."[25]

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[21] See, e.g., Medicaid & CHIP Payment & Access Comm'n, *Chapter 4: Integrating Clinical Care through Greater Use of Electronic Health Records for Behavioral Health* (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-4-Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-for-Behavioral-Health.pdf.

[22] Patient Access and Interoperability Final Rule, 42 C.F.R. §§ 422, 431, 438, 457; 45 C.F.R. § 156.

[23] Cong. Rsch. Serv., Artificial Intelligence in Health Care, R48319 (2024); Christian Wilhelm et al., *Benefits and Harms Associated with the Use of AI-Related Tools in Public Health*, 10 Lancet Pub. Health (2025), available at: https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(24)00314-4/fulltext.

[24] Jennifer Lubell, *How AI Is Leading to More Prior Authorization Denials*, Am. Med. Ass'n (Mar. 10, 2025), https://www.ama-assn.org/practice-management/prior-authorization/how-ai-leading-more-prior-authorization-denials.

[25] Michelle M. Mello et al., *The AI Arms Race in Health Insurance Utilization Review*, 45 Health Aff. 6 (2026), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2025.00897.

These uncertainties are compounded by the lack of transparency around how AI systems function and how they arrive at outputs. This provides little basis for evaluating their recommendations on appeal. When errors occur, providers and beneficiaries (not health plans, third-party vendors, or developers) must identify the problem, independently, navigate complex or hidden appeals processes, and prove that the system made a mistake. For disabled people, especially those with limited resources or support, these processes take on an even greater level of both urgency and difficulty. HHS must engage in a thorough analysis of risks and benefits specific to people with disabilities, and develop an auditing and regulatory framework to protect them.

Conclusion

While 62 percent of people with disabilities have an interest in AI development for health and wellness and even more believe AI has the potential to improve the lives of people with disabilities, most do not trust its current use.[26] For people with disabilities to build a solid foundation of trust in the use of AI in clinical settings, HHS must proceed carefully and prioritize the following principles:

- Fund future research and review current studies and stories of harm that disabled people (and others) have faced when interacting with AI tools and document any/all risk analyses.[27]
- Create standards for transparency and public disclosure of AI use, including underlying datasets, training protocols, and adherence to clinical guidelines.[28] People need to know when AI is used in clinical care and benefits determination, including the purpose, function, and scope of each use.[29] Transparency measures must also include public identification of any known limitations or biases of AI used in an easily accessible and understandable way.
- Mandate pre-deployment testing, effective auditing, and public reporting to identify risks, correct for bias, and publicly document disaggregated data. Some auditing approaches are inadequate and may inappropriately validate a flawed tool. Pre-deployment testing must include testing the accessibility of the AI systems and providing necessary accommodations.

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[26] Raeda Anderson et al., Artificial Intelligence and Disabled Adults: Current Use, Perceptions, and Future Developments, 106 Arch. Phys. Med. & Rehabil. E140 (2025), https://doi.org/10.1016/j.apmr.2025.01.363.

[27] *See, e.g.*, Joon Sung Park et al., *Designing an Online Infrastructure for Collecting AI Data from People with Disabilities*, Microsoft Research (Jan. 2021), https://www.microsoft.com/en-us/research/wp-content/uploads/2021/01/Inclusive_AI_Datasets_FINAL.pdf.

[28] Elizabeth Edwards & David Machledt, *Principles for Fairer, More Responsive Automated Decision-Making Systems*, Nat'l Health Law Program (May 2023), https://healthlaw.org/wp-content/uploads/2023/05/NHeLP_PrinciplesforFairerMoreResponsiveAutomatedDecisionSystems_05052023.pdf.

[29] R. Agarwal et al., *Addressing Algorithmic Bias and the Perpetuation of Health Inequities: An AI Bias Aware Framework*, 12 Health Pol'y & Tech. (2024), https://doi.org/10.1016/j.hlpt.2022.100702.

- Partner directly with people with disabilities[30] and low-income communities throughout the design, testing, and deployment of AI tools.
- Build AI requirements into procurement and vendor oversight, including enforceable transparency and accountability requirements so third party entities are subject to requirements.[31]
- Treat as high-risk any AI used in clinical decision-making, so that it can be subject to heightened protection at federal, state, and local levels.
- Enforce beneficiary rights, like clear and specific notice when AI leads to denials or unwanted modifications of care, review and correction of patient records and transcripts, appeals, and access to reasonable accommodation and policy modifications.
- Require independent, conflict-free medical judgment, not simply "human-in-the-loop," in medical necessity determinations.

CONCLUSION

Thank you for considering our input on the need to safeguard people with disabilities as HHS develops and deploys AI tools. If you have any questions, please contact Brit Vanneman (vanneman@healthlaw.org).

Sincerely,
The Undersigned Health TF Members

Access Ready Inc.

American Music Therapy Association

American Speech-Language-Hearing Association

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Center for Law and Social Policy (CLASP)

Center for Medicare Advocacy

CommunicationFIRST

Deaf Equality

[30] Eileen O'Grady, *Why AI Fairness Conversations Must Include Disabled People*, Harv. Gazette (Apr. 3, 2024), https://news.harvard.edu/gazette/story/2024/04/why-ai-fairness-conversations-must-include-disabled-people/.
[31] Ctr. for Democracy & Tech. and Am. Ass'n of People with Disabilities, *supra* note 1.

Disability Rights Education and Defense Fund (DREDF)

Justice in Aging

Muscular Dystrophy Association

National Health Law Program

The Arc of the US

United Spinal Association