



# BLUEPRINT FOR CHANGE 3.0

THE ARC OF INDIANA

Building a Better and More Meaningful Future for  
Hoosiers with Intellectual and Developmental Disabilities

**2026 EDITION**



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## ABOUT THIS BLUEPRINT

The Arc of Indiana first published *Blueprint for Change* in 2010 and followed with *Next Steps in the Journey* in 2017. Both brought legislators, state agencies, providers, families, and self-advocates together around a shared vision and plan to strengthen Indiana's system of services and supports for people with intellectual and developmental disabilities (IDD). Many of those plans were realized: Indiana continued to invest in and grow home and community-based services, and built new pathways to employment, including Erskine Green Training Institute in Muncie.

This edition, *Blueprint for Change 3.0*, responds to a different moment. Indiana's Medicaid waiver system is under significant strain. Waiting lists, new service limits, workforce shortages, and other challenges are affecting people with IDD and their families across the state. **This report offers a path forward—one that calls on Indiana to continue investing in home and community-based services while improving outcomes for people with IDD** and strengthening expectations and accountability for those who provide services.

Where possible, the recommendations are grounded in Indiana data, national research, and successful approaches from other states. Each objective includes ways to measure progress, helping Indiana determine what is working, where improvement is needed, and whether changes are making a meaningful difference in people's lives.



## OVERVIEW

For over seven decades, The Arc of Indiana has fought for opportunities that allow people with IDD to be valued, respected, and provided the supports they need to be as independent as possible.

***Today, Indiana stands at a pivotal moment in shaping the future of services and supports for people with IDD.***

While significant progress has taken place over the past two decades in expanding community services, today's environment presents challenges that threaten these gains if Indiana ignores its history and lessons learned.

The Medicaid program—the primary funding source for long-term services and supports—is under increasing financial and political pressure. Federal discussions regarding Medicaid restructuring, combined with rising healthcare costs, workforce shortages, provider instability, and increasing demand for services, require Indiana to rethink how disability supports are delivered.

At the same time, Indiana is positioned to become a national leader by modernizing its Medicaid system to improve outcomes while ensuring fiscal responsibility. Rather than relying on outdated service models that reward volume instead of results, **Indiana can build a stronger, more sustainable system centered on people and driven by measurable outcomes, accountability, innovation, and the effective use of technology.**

## THREE STRATEGIC PRIORITIES

The Arc of Indiana's **Blueprint for Change 3.0** proposes a strategic transformation of Indiana's **Medicaid-funded IDD support system** — not simply to preserve what exists, but to build something sustainable for the next generation. **This Blueprint is organized around three strategic priorities**, each with specific, measurable objectives:



### Improve Provider Accountability & Transparency

- Raise the bar for who is approved to serve Hoosiers with IDD
- Give families real information to choose a provider
- Treat direct support professionals (DSPs) as the skilled workforce they are



### Create a fully Person-Centered Support System

- Pay for outcomes instead of only units of service
- Make transition planning actually connect to adult life instead of ending at high school graduation
- Build a strong statewide crisis response system for people with IDD
- Put technology on equal footing with staffing as a support option



### Create an Effective Communication System

- Build one place families and providers can go for accurate information
- Hold state agencies to a response-time standard

**Indiana can build on efforts already underway and proven models** from other states. As this Blueprint shows, Indiana has already taken important steps, including piloting value-based payment models, creating a public waiver waitlist dashboard, and developing a workforce report with recommendations for strengthening the direct support workforce. **The next step is to move from planning and pilots to full implementation.**

Indiana can also learn from states that have gone further. Ohio, for example, established a Technology First Council with measurable goals and benchmarks, and a growing number of states have developed certified crisis response programs designed to meet the needs of people with IDD.

### Blueprint for Change 3.0 calls on Indiana to:

- Build on the progress already made
- Follow through on promising initiatives
- Adopt proven approaches that are working elsewhere.



## STRATEGIC PRIORITY ONE:



# IMPROVE PROVIDER ACCOUNTABILITY & TRANSPARENCY



Indiana's Medicaid provider network should represent excellence, professionalism, and accountability. **Serving Indiana's IDD population should be a privilege that is earned and maintained** — not a status granted once and never revisited.

While people with severe and profound disabilities may require intensive, round-the-clock care, specialized

medical equipment, behavioral health support, and highly trained DSPs, **a truly effective system requires enough providers willing and able to serve Hoosiers wherever they fall on the disability spectrum.**

### OBJECTIVE 1 Strengthen Provider Standards

Indiana should strengthen provider standards by implementing stricter requirements to become and remain an approved Medicaid provider.

#### Recommendations

- Enhanced financial review at initial enrollment and renewal
- Quality performance benchmarks tied to outcomes, not just paperwork completion
- Ongoing compliance monitoring rather than point-in-time inspections
- Performance-based recertification, so chronic low performers cannot simply renew indefinitely

Indiana is already moving in this direction. In August 2026, Indiana implemented a six-month moratorium on certifying and enrolling new Home and Community Based Service (HCBS) waiver provider organizations in response to concerns about provider capacity and oversight<sup>[1]</sup>. **Blueprint for Change 3.0 calls on Indiana to use this temporary pause as an opportunity to strengthen provider standards for the long term.** Before lifting the moratorium, the state should establish stronger certification and oversight requirements to ensure organizations entering the system have the capacity, qualifications, and accountability needed to provide high-quality services and supports.

#### Measuring Success

- A published, state-verified list of active provider certifications and any conditions attached to them
- A year-over-year decline in the number of providers operating under a corrective action plan for more than 12 months

## STRATEGIC PRIORITY ONE:

### OBJECTIVE 2 Build a Provider Performance Portal

People with IDD and their families deserve access to meaningful information about provider performance, and providers must be transparent and accountable for the services they deliver and bill.

#### Recommendations

To support informed choice and drive continuous quality improvement, Indiana should create an online Provider Performance Portal that includes:

- Services offered and geographic coverage
- Staff stability and turnover indicators
- Satisfaction survey results and quality metrics
- Complaint history
- Provider specialties and current availability

Indiana does not need to start from zero. The state participates in the National Core Indicators (NCI) program<sup>[2]</sup> — a national, cross-state data collection effort that gathers standardized outcome and satisfaction data — and the state operates a public BDS Gateway Waitlist Portal and an Online HCBS Waitlist Dashboard<sup>[3]</sup>. **A Provider Performance Portal would extend infrastructure Indiana has already built**, pairing data the state already collects through NCI with the provider-level detail families need when choosing who supports their loved one.

#### GROUNDING IN PRACTICE

California has implemented a centralized Provider Directory that is used by regional centers and providers to strengthen provider information, vendorization, quality tracking, and system capacity. California DDS has identified public-facing access for individuals and families as part of the directory's continued development.<sup>[4]</sup> Indiana would not be inventing this concept — it would be adapting a working model.

California's Quality Incentive Program offers a model for moving from planning to implementation, tying financial incentives to measurable quality outcomes developed with stakeholder input, including employment and health outcomes<sup>[5]</sup>.

#### Measuring Success

- Portal live and updated at least quarterly, with usage tracked
- Family survey data showing increased confidence in choosing a provider
- An improved, user-friendly pick list for individuals and families

## STRATEGIC PRIORITY ONE:

### OBJECTIVE 3 Reward Providers that Demonstrate Excellence

Indiana should reward providers that demonstrate excellence and incentivize high performance, rather than paying every provider identically regardless of outcomes.

#### Recommendations

Potential provider incentives:

- Enhanced reimbursement for demonstrated quality
- Innovation grant opportunities
- Reduced administrative burden for high performers
- Enhanced reimbursement for serving those with more intensive needs
- Preferred provider designation

Outcomes for individuals served to measure performance:

- Employment outcomes, including workforce retention
- Community integration
- Improved and/or stable health/behavior outcomes
- Technology adoption
- Family satisfaction

**INDIANA SHOULD  
REWARD  
PROVIDERS THAT  
DEMONSTRATE  
EXCELLENCE**

This is not a new idea for Indiana. The state was selected for two rounds of the federal Centers for Medicare & Medicaid Services' (CMS) Medicaid Innovation Accelerator Program focused on value-based payment for long-term services and supports — a planning cohort in 2016 and a design cohort in 2018<sup>[6]</sup>. Indiana has participated in two CMS technical-assistance initiatives focused on developing and designing value-based HCBS payment approaches. That work provides a foundation for further testing and implementation.

One important safeguard should be built in from the start: **a “preferred provider” designation should be evaluated for its effect on participant choice and rural access**, where provider options may already be limited, before it is tied to referrals. **The goal should be to strengthen quality without limiting access** to needed services and supports.

#### Measuring Success

- New provider payment model implemented no later than July 1, 2028, at the time of Waiver Reset.
- Publicly reported list of preferred/high-performing providers and/or designation on the provider pick-list.



## STRATEGIC PRIORITY ONE:

### OBJECTIVE 4 Recognize DSPs/HCSPs as Essential Professionals

Indiana's official training program now refers to direct support professionals (DSPs) as home and community support professionals (HCSPs). **DSPs/HCSPs should be recognized and supported as essential professionals**, with competitive compensation, opportunities for advancement, and a clear career path that helps Indiana recruit and retain a skilled, stable workforce.

#### Recommendations

- Career ladders or pathways for current DSPs
- Explore a DSP pathway for people with IDD who want to work in the field
- Statewide credentialing
- Tuition assistance
- Leadership development
- Wage enhancement tied to demonstrated competency
- Early career awareness and K–12 exploration opportunities



#### GROUNDING IN PRACTICE

Indiana's 2023 Direct Service Workforce Report recommended many of these same steps, including a standardized statewide definition of "direct service worker," a web-based credential registry, career and education pathways, and a formal Wages and Benefits Action Group<sup>[7]</sup>. Indiana has already made progress. DDARS now operates a statewide Home and Community Support Professional (HCSP) Training, creating the standardized credentialing infrastructure envisioned in the workforce report<sup>[8]</sup>. Indiana has also demonstrated that significant workforce investment is possible. During the pandemic, the state directed approximately \$130 million in HCBS Workforce Investment Grants, with 95% required to pass through directly to workers, as well as \$176 million in Provider Stabilization Grants<sup>[9]</sup>. The recommendation is to move beyond one-time emergency investments and build a permanent workforce strategy.

#### Measuring Success

- Reduced DSP vacancy rate, tracked annually through the NCI Staff Stability Survey
- Increased average DSP tenure
- At least one statewide credentialing pathway launched



**[My] number one concern is the quality of care [People] are getting, because staff turnover is so quick... every time they go in that home, it's a whole new group of staff, and nobody knows anything about the individuals, other than 'we're supposed to keep them safe.**

*Blueprint for Change 3.0 Committee*



# START

## BY THE NUMBERS

### AND WHAT INDIANA HAS ALREADY DONE

**17,547** DSPs across **170** provider agencies were represented in Indiana's 2024 NCI State of the Workforce survey. **Indiana's median DSP wage was \$16.02 per hour**, compared with **\$18.39** nationally, and **annual turnover was 43.8%** compared with **41.8%** nationally.

**46,709** Hoosiers were enrolled in Indiana's HCBS waiver programs as of February 2025, with another **2,589 people** supported through Supervised Group Living.

An estimated **113,900** Hoosiers with IDD — about **73% of Indiana's estimated IDD population** — live with family caregivers, many outside the formal waiver system.

Nearly **60% of family caregivers** are age 41 or older, including **24% who are age 60 or older**, highlighting the need to plan for future formal support needs.

Indiana has already shown that targeted workforce investment is possible. **The state established a statewide HCSP Training and Registry and previously directed approximately \$130 million in HCBS Workforce Investment Grants**, with **95%** required to pass through **directly to workers**, along with **\$176 million in Provider Stabilization Grants**. These efforts provide a foundation for moving from one-time workforce investments toward a permanent career and compensation strategy.



## STRATEGIC PRIORITY ONE:

### OBJECTIVE 5 Modernize Service Delivery and Reduce Regulatory Burden

**Administrative complexity diverts resources from direct supports.** Indiana has already committed to this direction. The state's Waiver Reset initiative aims to reduce assessments and paperwork, establish uniform support coordination across waivers, and move toward quality-based provider payments<sup>[10]</sup>. With a new youth waiver targeted for July 2027, followed by redesigned adult waivers in 2028, Blueprint for Change 3.0 calls on the legislature and FSSA to consider these recommendations for meaningful reform.

Streamlining processes can make the system more efficient, but **without adequate investment in services and supports, administrative reform alone will not reduce waiting lists or ensure people with IDD receive the support they need.**

**ADMINISTRATIVE REFORM  
ALONE WILL NOT REDUCE  
WAITING LISTS OR ENSURE  
PEOPLE WITH IDD RECEIVE  
THE SUPPORT THEY NEED.**

#### Recommendations

- Simplify documentation
- Reduce duplicative reporting
- Modernize billing systems
- Improve electronic records
- Expand mobile documentation

#### Measuring Success

- Measurable reduction in average hours case managers spend on duplicative paperwork per participant per year
- BDS Waiver Reset milestones are met according to the published implementation timeline

### OBJECTIVE 6 Become a Technology First State

**Indiana should become a Technology First state,** ensuring that technology-based supports are a viable option for consideration in person-centered planning meetings.

#### Recommendations

- Implement technology assessments as a standard part of planning
- Offer provider training on available technology
- Conduct demonstration projects
- Fund assistive technology and equipment
- Ongoing technical assistance



## STRATEGIC PRIORITY ONE:

As of the most recent national benchmark survey, 40 states reported some form of **Technology First initiative** or legislation; **Indiana was among 11 states that had not yet reported adopting one**<sup>[11]</sup>. Ohio offers a working model. Governor John Kasich's 2018 executive order created a Technology First Council that set five measurable benchmarks, including getting all 88 Ohio counties access to Medicaid-funded technology services, requiring technology to be discussed at every person-centered planning meeting, and growing the pool of certified technology vendors from six to ten<sup>[12]</sup>. **Indiana should adopt a comparable executive order or statute establishing its own Technology First Council** with published, dated benchmarks.

### Measuring Success

- Formal Technology First designation adopted by executive order or statute, with a named council and reporting requirement
- Increased independent living
- Reduced reliance on staffing where technology is an appropriate substitute
- Higher satisfaction among people using technology-enabled supports

## STRATEGIC PRIORITY TWO:



## CREATE A TRULY PERSON-CENTERED SUPPORT SYSTEM

We must create Indiana's Medicaid **system that is based on needs, outcomes, and goals that are driven by the person and/or their family.**

Medicaid **must see the person as a whole person**, not just a person with a disability. This means keeping in mind all of someone's health needs, their living environment, and their personal strengths and goals. Indiana's Medicaid program's success should be **measured by improvements in quality of life rather than units of service delivered.**



**We have to see people for what they can do—taking every positive strength and focusing on that rather than starting with weaknesses.**

*Blueprint for Change 3.0 Committee*



## STRATEGIC PRIORITY TWO:

### OBJECTIVE 1 Transition to Value-Based, Outcomes-Driven Funding

Indiana's **current reimbursement models reward service volume rather than outcomes**. Value-based funding shifts the fundamental question from "did the provider follow the rules?" to "did the person actually get better outcomes?" **Provider incentives should be aligned with what actually matters** and the value brought to the people being served.

**Traditional compliance-based models pay providers for completing prescribed activities**—documenting a visit, delivering a set number of service hours, checking off required tasks—**regardless of whether those activities meaningfully improved a person's life**. This can reward paperwork over progress and gives providers little incentive to innovate, since they get paid the same whether an individual thrives or merely receives the minimum required service.

**Value-based funding, by contrast, ties payment or incentives to measurable results:** Did the person gain new skills, increase independence, find or keep employment, improve their health, or avoid unnecessary hospitalizations?

**Moving to value-based funding requires Indiana to define success differently.** Rather than measuring only services delivered and requirements met, the state should measure whether people are achieving the goals that matter to them and whether services are improving their lives. These outcomes should then help guide how Indiana rewards quality and performance.

As outcomes are harder to track than simple service delivery, **this approach demands better data collection and more thoughtful metrics**. Moving away from a checklist mentality toward genuine accountability for results encourages providers to be more creative, person-centered, and responsive—ultimately building a system that rewards real impact rather than mere participation.



This outcomes-based payment model **must supplement existing service payments and incentivize results**, rather than withhold payment based on outcomes.

**Indiana's Medicaid waiver reimbursement rates have long lagged behind the actual cost of delivering quality care**, creating strain across the state's disability services system. **Low rates make it difficult for provider agencies to offer competitive wages** to DSPs – a workforce that is already in short supply and facing high turnover nationwide.

## STRATEGIC PRIORITY TWO:

### Recommendations

Establish measures for individual progress, not just standardized outcomes, based on each person's goals, choices, and vision for their life. Measures should assess whether people:

- Make progress toward goals important to them
- Have choice and control over where they live, work, and spend their time
- Participate in their communities and build meaningful relationships
- Develop skills and increase independence
- Feel safe, respected, supported, and satisfied with their services

Implement value-based provider payments as incentives above adequate base reimbursement rates, not as a holdback of existing provider funding.

**PROVIDER INCENTIVES  
SHOULD BE ALIGNED  
WITH THE VALUE  
BROUGHT TO THE PEOPLE  
BEING SERVED.**

### Measuring Success

- Increased progress toward goals identified by people receiving services
- Increased choice, independence, community participation, and satisfaction
- Increased competitive integrated employment for people who identify employment as a goal
- Reduced avoidable hospitalizations, crises, emergency placements, and institutional admissions
- Improved access to and continuity of needed services
- No disparities in outcomes or access based on level of support need

**A note on surveys:** Satisfaction surveys can be valuable, but only if they ask the right questions. Broad questions such as "How satisfied are you overall?" may produce a score without identifying what is working, what is not, or what needs to change.

Surveys should focus on specific experiences that matter to people with IDD and their families—whether they feel heard and respected, have meaningful choices, receive reliable supports, are making progress toward their goals, and believe their services are helping them live the life they want. People should also have opportunities to explain their responses in their own words.

Survey questions should be developed and periodically reviewed with people with IDD and families. Results should be used not simply to generate a satisfaction score, but to identify areas for improvement and measure whether changes are making meaningful differences.

*See Strategic Priority One, Objective 3 for the specific provider incentives and Indiana's existing history with CMS value-based payment planning.*

## STRATEGIC PRIORITY TWO:

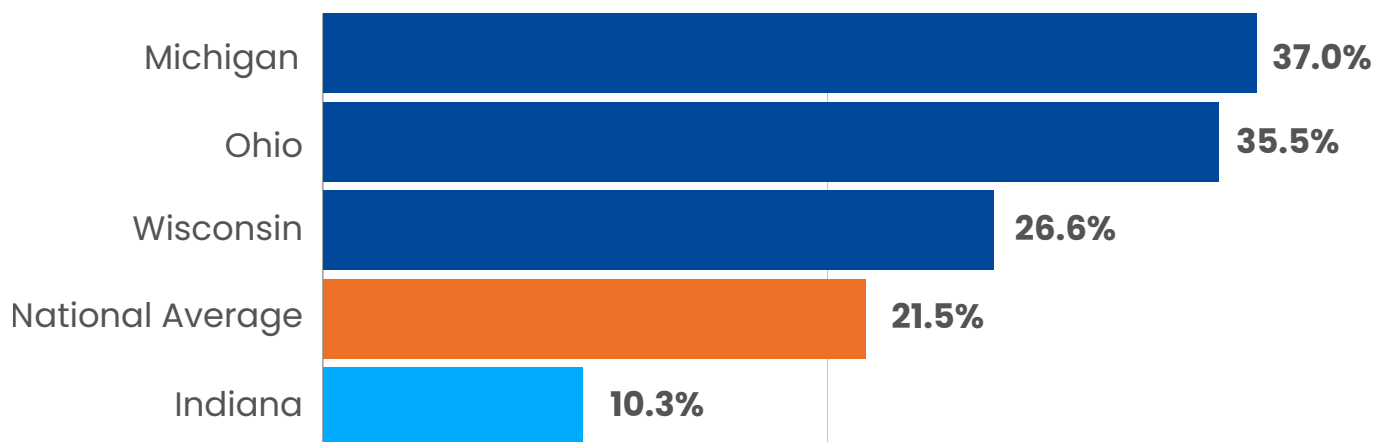
### OBJECTIVE 2 Strengthen Transition Planning (Ages 14–24)

**Indiana law already requires a Transition IEP to be in effect by ninth grade or age 14, whichever comes first<sup>[13]</sup>.** The gap is not the legal deadline; it is in the consistency of implementation and how well school-based planning actually connects to adult employment, Medicaid, and Vocational Rehabilitation systems once a student ages out. **For transition services to truly work, strong collaboration is needed across the Department of Education and the Bureau of Rehabilitation Services (BRS).**

Indiana has had success with its Pre-Employment Transition Services (Pre-ETS) program, and it should remain a priority. Pre-ETS provides employment preparation and work-based learning opportunities to students with disabilities ages 14–22. A growing body of peer-reviewed research links early, individualized Pre-ETS to stronger employment outcomes after students leave school<sup>[14]</sup>.

The stakes of getting this right are real: **national data** collected through the National Core Indicators program **shows only about 17% of adults with IDD hold a paid job in the community**, even though 42% of those without one say they want one<sup>[15]</sup>. **Earlier, better-coordinated transition planning is one of the few levers shown to move that number.**

#### Competitive Integrated Employment Participation: Indiana and Selected Benchmarks



*Source: Nord, D., & Hamre, K. (2026), A Preventable Crisis, Indiana Institute on Disability and Community, Indiana University, p. 13, using StateData Bluebook figures. Methodology note: StateData uses a common denominator across states for this comparison. These percentages are not directly comparable with NCI-IDD or Indiana DESOS employment rates, which measure different populations and use different denominators.*

## STRATEGIC PRIORITY TWO:

### Recommendations

Hoosier **students with IDD need school-to-work systems**, so a transition plan doesn't stay a paper exercise. Transition services should:

- Hold every school corporation to the existing age-14 through ninth-grade requirement
- Create individualized transition roadmaps
- Integrate schools, Vocational Rehabilitation, Medicaid, employers, and families
- Expand paid work experiences before graduation
- Increase vocational training and postsecondary education opportunities
- Establish statewide transition coordinators

### Measuring Success

- Increased meaningful community employment within one year of graduation
- Increased use of vocational training and/or postsecondary enrollment following graduation
- Reduced service gaps after high school
- Independent living outcomes chosen by the person, with Medicaid supports sized to actual need rather than defaulted to the maximum

### OBJECTIVE 3 Build a Statewide Crisis Continuum

**Indiana does not have a strong crisis and high-acuity infrastructure for people with IDD and their families.**

Although the Administration for Community Living estimates that at least one in three people with IDD also has a co-occurring mental health condition, Indiana's 988 program is not sufficient for people with IDD or a co-occurring IDD diagnosis<sup>[16]</sup>.

**ONE IN THREE  
PEOPLE WITH IDD  
ALSO HAS A  
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MENTAL HEALTH  
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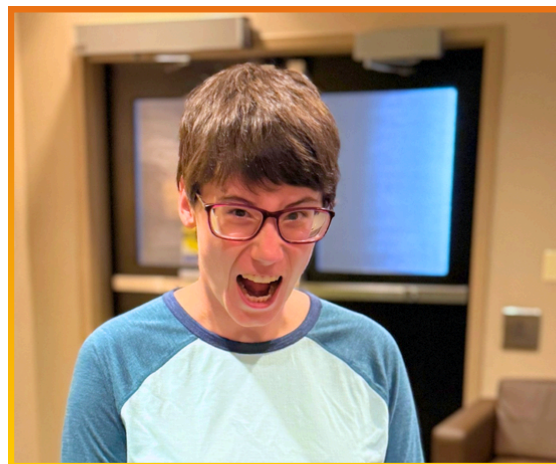
**Indiana's 988 program is a valuable resource, but it was designed primarily around suicide prevention and general behavioral health crises, not the specific needs of people with IDD.** Crisis specialists and mobile crisis teams are trained to assess safety and connect callers to mental health or substance use services, but they aren't necessarily equipped to recognize IDD-related communication differences, sensory needs, or behavioral presentations that can look very different from a typical mental health crisis. Without that specialized training, a person with IDD in crisis risks being misunderstood, mismanaged, or funneled toward the wrong interventions. **A true crisis solution** for this population **requires responders who understand IDD specifically**, along with clear pathways to disability-competent follow-up care, not just a general-purpose hotline layered on top of a system that wasn't built with them in mind.

## STRATEGIC PRIORITY TWO:

### Recommendations

Too many individuals and families reach a full-blown crisis before receiving any meaningful intervention. **Indiana should establish a statewide IDD crisis continuum** that includes:

- Mobile crisis teams
- Specialized behavioral stabilization services
- Short-term respite centers
- Emergency housing options
- Intensive in-home supports
- Behavioral consultation networks



### GROUNDING IN PRACTICE

Multiple states demonstrate what an IDD-specific crisis continuum can look like. Some programs provide 24/7 crisis assessment and intervention for people with developmental disabilities experiencing behavioral or psychiatric crises. Some include mobile crisis response in the community, short-term stabilization services, and Crisis Therapeutic Homes when a person cannot safely remain in their current setting. There are some statewide policies that explicitly call for crisis prevention, proactive planning and community-based responses intended to prevent unnecessary removal from a person's home or placement.

**Other states demonstrate that this specialized expertise can also be connected directly to a general crisis system.** One state has a statewide crisis access line that can dispatch mobile teams that respond specifically to behavioral-health and IDD crises.

These examples illustrate that **Indiana does not need to replace 988 or create an entirely separate crisis system. It can build an IDD-specific continuum behind the existing front door**—giving general crisis responders access to disability-trained professionals, mobile response, stabilization options, and coordinated follow-up when a person's disability changes what an effective crisis response requires.

### Measuring Success

- Fewer emergency room visits
- Fewer institutional placements
- Reduced caregiver burnout
- Faster crisis response times, tracked and reported publicly



## STRATEGIC PRIORITY TWO:

### OBJECTIVE 4 Expand Community-Based, Technology-Enabled Supports

Indiana's documented direct-service workforce shortage means the state cannot rely on staffing alone to meet every need. **Indiana must also expand and support technology-enabled community-based supports** as a genuine complement to a properly staffed system, not a justification for understaffing it.

#### Recommendations

Indiana should develop a system of community-based, technology-enabled supports that could include:

- Remote supports
- Smart home technology
- Medication monitoring
- Safety technology
- Telehealth
- Virtual skill-building
- Transportation technology

**INDIANA'S  
DSP/HCSP  
WORKFORCE  
SHORTAGE MEANS  
THE STATE  
CANNOT RELY ON  
STAFFING ALONE.**

*This objective is the direct-service counterpart to Strategic Priority One, Objective 6 (Become a Technology First State) — see that section for Indiana's current standing and the Ohio model this Blueprint recommends Indiana adopt.*

#### Measuring Success

- Increased use of technology-enabled supports
- Increased independent living
- Reduced impact of staffing shortages on service delivery
- Improved safety outcomes
- Higher satisfaction among individuals, families, and staff



## STRATEGIC PRIORITY THREE:



# CREATE AN EFFECTIVE COMMUNICATION SYSTEM



**Communication remains one of the greatest sources of frustration for families and providers alike.**

Indiana should develop an integrated, streamlined communication strategy that delivers timely, accurate, and accessible information to everyone who needs it.



**If it's as challenging as it's been for myself, my wife, and my family, it gets virtually impossible for some people. It's incredibly painful at times, the things I've had to go through to make sure our child has gotten the benefits that he should get.**

*Blueprint for Change 3.0 Committee*



### **OBJECTIVE 1** Create a Statewide Unified Information Portal

Families, **people with IDD, and providers should not have to search across multiple websites and systems to find critical information** about services, policies, and requirements. Indiana should create a single, reliable source for current information that is easy to find, understand, and use.

#### **Recommendations**

Indiana should build a single, unified information portal that provides:

- HCBS Waiver service details
- State notices and bulletins
- Total spend information
- Provider billing and payment information
- Upcoming reviews
- Frequently asked questions, in plain language

Indiana has already built pieces of this: the BDS Gateway Portal and the online HCBS Waitlist Web Portal both show that the state can stand up public-facing tools when it chooses to<sup>[17]</sup>.

**The recommendation here is to consolidate and expand the state's existing infrastructure into one destination, rather than requiring families to know which of several separate state tools to check.** This is also increasingly a legal requirement, not just good practice: CMS's 2024 Access Rule requires states to publicly report HCBS quality, performance, compliance, and waiting list data as its provisions phase in over the next several years<sup>[18]</sup> — a unified portal is the natural place to meet that obligation.

## STRATEGIC PRIORITY THREE:

### Measuring Success

- Portal launched with all six information categories live
- Reduced call volume to case managers for information already available on the portal, tracked year over year



### OBJECTIVE 2 Establish State Communication Standards

**Clear and timely communication should be a basic expectation across state agencies.** People with IDD, families, and providers need consistent standards for when they can expect a response and information that is understandable and accessible to everyone.

### Recommendations

Establish response and communication standards for state agencies that include:

- Email responses within two business days
- Plain-language guidance that can be understood without a specialized background
- Accessible communications for people with vision, hearing, cognitive, or intellectual disabilities

**Accessibility here is not optional.** Under a 2024 U.S. Department of Justice rule implementing Title II of the Americans with Disabilities Act, state and local government web content and mobile apps must meet the WCAG 2.1 Level AA accessibility standard, on a compliance timeline based on population<sup>[19]</sup>. Whatever the final deadline, Indiana's Unified Information Portal and every other public-facing tool this Blueprint recommends should be built to that standard from the start, rather than retrofitted later.

### Measuring Success

- Published and tracked response-time compliance rate for state agencies
- Independent readability review of public-facing guidance documents
- WCAG 2.1 Level AA compliance verified for all new and redesigned state disability-services web content

# CONCLUSION

**Over the last two decades, it has been proven that community-based services improve lives and strengthen communities.** Indiana's investment in community-based services is a more cost-effective use of Medicaid dollars. An Indiana University analysis found that average annual Medicaid spending was approximately \$25,042 per person receiving home and community-based Medicaid waiver services compared with \$93,649 per person receiving services in an Intermediate Care Facility for People with Intellectual and Developmental Disabilities (ICF/IID) institutional setting—about 3.7 times as much.

Having moved away from institutions that merely maintained lives toward community services that value people and promote independence, Indiana should not lose sight of that lesson now. **A sustainable system is one that is accountable, centered on the abilities and goals of each individual, and reinvests savings** from models that don't work into models that do.

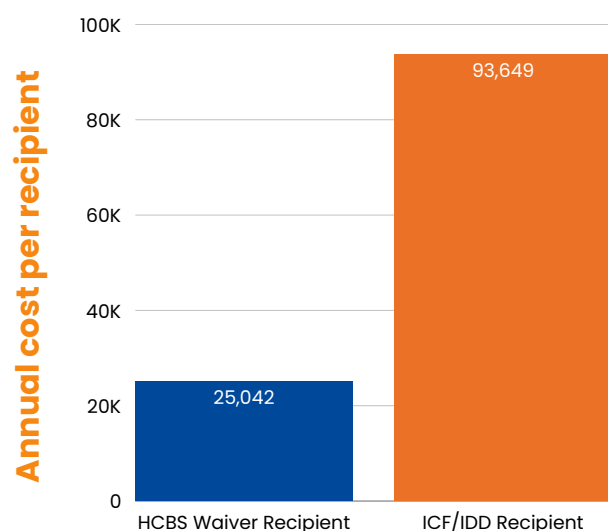
**The time for incremental change has passed.** Indiana must act now to preserve the promise of community supports, protect the long-term sustainability of Medicaid-funded services, and build a system that delivers better outcomes for individuals, families, providers, and taxpayers alike.

**Blueprint for Change 3.0 provides a practical roadmap for transformation, grounded in Indiana data, commitments already made, and proven approaches from other states.** By embracing these recommendations, Indiana can build a stronger, more meaningful system that meets today's challenges and prepares for the future.

The Arc of Indiana is committed to working alongside policymakers, state agencies, providers, self-advocates, families, and community partners to implement these reforms. **Together, we can ensure that every Hoosier with an intellectual or developmental disability has the opportunity to live, work, learn, and thrive in the community of their choice.**

## Average Annual Medicaid Spending Per Recipient, Indiana

*System-level averages using a consistent methodology*



### RELATED COST ESTIMATES

The IU analysis also reports:

- An adjusted average waiver cost of \$45,700 per participant
- An estimated residential cost of approximately \$425,000 per person for a large private ICF/IID with 16 or more residents

*These figures come from different datasets and methodologies and should not be interpreted as direct equivalents to the system-level averages.*



Using the same system-level methodology, average annual Medicaid spending per ICF/IID recipient was approximately **3.7 times** the average spending per HCBS waiver recipient.

*Source: Nord, D., & Hamre, K. (2026). A Preventable Crisis: How Institutional Spending Concentration Undermines Indiana's Community-Based IDD System. Indiana Institute on Disability and Community, Indiana University. System-level averages are based on Residential Information Systems Project (RISP) FY2021 data.*



# COMMITTEE MEMBERS

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## Co-Chairs

Dick Rhoad, IDD Professional  
Cody Mullen, Sibling

## Self-Advocates

Melody Cooper – Self-Advocate  
Shawn Fulton – Self-Advocate  
Erin McGuire – Self-Advocates of Indiana President  
Samara Pfeifer – Self-Advocate  
Lexi Westerfield – Self-Advocates of Indiana Sergeant-at-Arms

## Parents & Siblings

Adam Brown – Sibling  
William Hawkins – Parent  
Kylee Hope – Sibling  
Alan Kaffenberger – Parent

## IDD Professionals

Karen Brummet – IPMG CEO/President  
Tom Crishon – The Arc of Indiana Chief Legal Officer  
Nash Dunn – KCARC President  
Donna Elbrecht – Easterseals Northern Indiana CEO/President  
Yolanda Kincaid – Sycamore Services CEO  
Andy Kirby – ILADD Executive Director  
Wendy Kirtz – The Arc of Bartholomew County Executive Director  
Jason McManus – Wabash Center/The Arc of Tippecanoe County CEO/President  
Dr. Derek Nord – Indiana Institute on Disability and Community at Indiana University Director  
Katy Stafford Cunningham – INARF CEO/President  
Tammy Themel – accessABILITY CEO  
Pam Verbarg – The Arc of Greater Boone County Executive Director  
Dr. Jim Wiltz – Kestrel Behavioral Health Co-Founder  
Wade Wingler – Noble/The Arc of Greater Indianapolis CEO/President

# KEY TERMS

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A handful of acronyms and technical terms appear throughout this document. They are defined here once so each section can move quickly.

**Case Manager / Service Coordinator:** The professional who helps an individual or family build and manage their waiver service plan, connect with providers, and navigate the system.

**Community Integration:** People with disabilities living, working, learning, participating, and building relationships in their communities alongside people without disabilities, with the same opportunities for choice, independence, and belonging as other community members.

**Competitive Integrated Employment (CIE):** A competitive integrated job in the community, paid at least minimum wage, working alongside people without disabilities — as distinct from sheltered workshops or facility-based work.

**DSP / HCSP:** Direct Support Professional — the front-line worker who provides day-to-day, hands-on support: personal care, transportation, community access, skill-building, and safety supervision. Indiana's own training and registry program now uses the term Home and Community Support Professional (HCSP) for this same role. DSPs/HCSPs are the workforce this entire system depends on.

**FSSA / DDARS:** The Indiana Family and Social Services Administration and its Division of Disability, Aging and Rehabilitative Services, which together administer Indiana's IDD Medicaid waivers through the Bureau of Disability Services (BDS).

**HCBS:** Home and Community-Based Services — the Medicaid-funded services (personal care, respite, day services, supported employment, and similar) delivered in a person's home or community rather than in an institutional setting.

**IDD:** Intellectual and Developmental Disabilities. A broad term used here to include intellectual disability and developmental disabilities that begin during the developmental period and may substantially affect learning, communication, mobility, self-direction, independent living or other areas of daily life. Intellectual disability is characterized specifically by significant limitations in intellectual functioning and adaptive behavior.

**ICF/IID:** Intermediate Care Facility for Individuals with Intellectual Disabilities. A Medicaid-funded residential facility that provides 24-hour services and supports to individuals with intellectual disabilities. Unlike HCBS Waiver services, which support people living in homes and community-based settings, ICF/IID services are provided through a facility-based model. Large ICF/IIDs are facilities defined as serving 8 or more people (but in reality serve more than 16 people). Indiana defines small ICF/IIDs as group homes that serve 4-8 people with oversight from the Department of Health rather than BDS/DDARS.

**Level of Care (LOC):** The eligibility standard used to determine whether a person's needs meet the level of care that would otherwise qualify them for services in an institutional setting. Assessment information is used to determine whether that standard is met.

**Medicaid Waiver:** A federal program that allows Indiana to use Medicaid dollars to pay for services in a person's home or community — instead of in an institution. Indiana's IDD waivers are the Family Supports Waiver (FSW) and the Community Integration and Habilitation Waiver (CIH). Waivers have a state-set enrollment cap, commonly called “slots.” The CIH Waiver is considered an emergency waiver and therefore does not have a traditional waiting list.

**Person-Centered Planning:** A planning process built around an individual's own goals, preferences, and strengths, rather than fitting the person into a predetermined program model.

**Value-Based Payment (VBP):** A reimbursement approach that ties some or all of a provider's payment to measurable outcomes and quality, rather than paying only for the volume of units delivered.

## A NOTE ON SOURCES

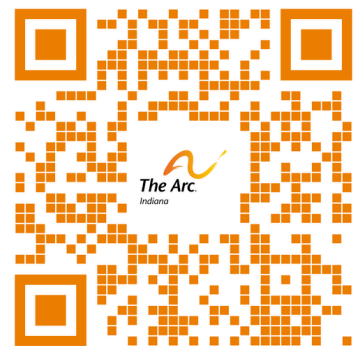
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Statistics, examples, and program references throughout Blueprint 3.0 are supported by numbered endnotes, direct source attributions, and additional references provided with this report. Waitlist figures, service caps, and waiver structures are all in active flux as of this writing — readers using this document for legislative or budget purposes should confirm current figures directly with Indiana FSSA/DDARS before citing them publicly.

**Primary source categories used throughout this document include:**

- Indiana FSSA and its Division of Disability, Aging and Rehabilitative Services, including its official waiver filings with CMS ([in.gov/fssa](https://www.in.gov/fssa))
- The Arc of Indiana ([arcind.org](https://arcind.org))
- The federal Centers for Medicare & Medicaid Services, including the 2024 Ensuring Access to Medicaid Services (HCBS Access) rule ([medicaid.gov](https://www.medicare.gov))
- The U.S. Department of Justice's ADA Title II web accessibility rule ([ada.gov](https://www.ada.gov))
- The U.S. Administration for Community Living ([acl.gov](https://www.acl.gov))
- Indiana Administrative Code ([511 IAC](https://www.511iac.org), via [regulations.justia.com](https://www.regulations.justia.com))
- PHI National, the leading research organization on the direct care workforce ([phinational.org](https://www.phinational.org))
- The National Core Indicators program ([nationalcoreindicators.org](https://www.nationalcoreindicators.org))
- California's Department of Developmental Services ([dds.ca.gov](https://www.dds.ca.gov))
- The University of Kansas's State of the States in Intellectual and Developmental Disabilities project ([stateofthestates.ku.edu](https://www.stateofthestates.ku.edu))
- The National Association of State Directors of Developmental Disabilities Services ([nasddds.org](https://www.nasddds.org))

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Since 1956, The Arc of Indiana has been here to help Hoosiers with intellectual and developmental disabilities and their families realize their goals of learning, living, working, and fully participating in the community. Throughout our history, The Arc of Indiana has worked alongside families to serve as a trusted resource and advocate for opportunities that help their loved ones live their best life.

From fighting for inclusion in public education to closing all of Indiana's state-run institutions, The Arc of Indiana has always taken on issues important to people with disabilities and their families.

While we have achieved much success, we are not done yet.

