A Preventable Crisis: How Institutional Spending Concentration Undermines Indiana's Community-Based IDD System

A research brief on Indiana's home- and community-based services (HCBS) system for people with intellectual and developmental disabilities (IDD)

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REVISION NOTE

This September 2026 revision corrects and clarifies the classification of Supervised Group Living (SGL) within Indiana's IDD service system. SGL is a Medicaid certified ICF/IID service model. Related descriptions of ICF/IID services, enrollment, and cost comparisons have been revised accordingly. The underlying datasets and principal findings of the brief are unchanged.

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About the Institute

The Indiana Institute on Disability and Community (IIDC) is Indiana's University Center for Excellence in Developmental Disabilities (UCEDD), housed at Indiana University. UCEDDs are federally designated centers, authorized under the Developmental Disabilities Assistance and Bill of Rights Act, that exist in every state and territory. Their mandate is to advance the independence, productivity, and community inclusion of people with developmental disabilities through research, training, technical assistance, and dissemination. IIDC carries out this mission through seven centers whose work spans community living, employment, education, behavioral health, recreation and public lands, and the development of digital tools and platforms that connect people with the resources and information they need. The institute has served Indiana and the broader disability field for more than fifty years.

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Executive Summary

Indiana has spent four decades building one of the most extensive community-based disability service systems in the country. The data are now telling a clear story about what that investment has produced, where it falls short, and what it will take to sustain it. This brief draws on 12 data sources spanning four decades to document what Indiana has built, what it costs, what it produces, and what it will need to sustain going forward. The data presents a clear picture: Indiana does not have a resource problem in its IDD service system. It has a resource allocation problem. The public dollars exist. They are concentrated in the most expensive settings, serving the fewest people, producing outcomes that fall well short of what the data show community-based supports can deliver. The central finding is consistent across every source: Continuing Indiana's four-decade shift from institutional to community-based care is both fiscally sound and the most effective path to serving more Hoosiers who are currently waiting for services to support living and thriving in their communities of choice.

Who depends on these supports, and who is waiting for them. As of early 2025, 46,709 Hoosiers were enrolled in Medicaid Home and Community Based Services (HCBS) waivers. Separately, 2,589 people received services through Supervised Group Living (SGL), Indiana's predominant small home ICF/IID model. At the same time, more than 13,600 people were waiting to receive waiver services, including approximately 6,800 children under age 13 on the Family Supports Waiver waiting list alone. The Community Integration and Habilitation Waiver had zero remaining capacity as of early 2026. Applications for services grew 150% between 2020 and 2024. An estimated 113,900 Hoosiers with IDD live with family caregivers, many without formal waiver services. Nearly 60% of those caregiving families have a primary caregiver who is middle aged or older.

What the system is producing. Consumer outcome data from the National Core Indicators (NCI) Indiana In-Person Survey shows meaningful community participation and strong choice indicators in several life domains, with Indiana performing at or above national benchmarks on community inclusion, residential choice, and health access. The same data identifies persistent gaps in self-determination, particularly in everyday spending decisions and staff choice, and in social connection, where 71% of Indiana respondents want help making or keeping contact with friends. One in five families report that their family member does not consistently receive all services listed in their plan. Rather than evidence of a failing system, these data show a working system that has measurable room to improve with continued investment.

What it costs and what reallocation produces. Residential Information Systems Project (RISP) data from fiscal year 2021 shows Indiana's average cost per Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) recipient was $93,649 compared with $25,042 per waiver recipient in the same year—a nearly 4-to-1 cost differential within the same dataset. State of the States residential data shows the differential runs higher at the facility level: large private ICF/IID settings cost $425,000 per person annually versus $73,600 for supported living. Indiana's adjusted waiver cost per participant fell to $45,700 in fiscal year 2023, down from a peak of roughly $105,000 in inflation-adjusted terms in 2009, meaning Indiana has expanded community-based enrollment while reducing per-person cost in real terms. At current waiver costs, the annualized cost of a single large institutional placement could fund between two and nine community waiver participants depending on setting. In FY2021, ICF/IID services accounted for 8% of combined waiver and ICF/IID recipients but 26% of combined waiver and ICF/IID expenditures. That is where the budget pressure in Indiana's IDD system originates.

Additional stressors to the community-based system. The cost picture is best contextualized alongside additional information sources. Three additional findings document the strain on a system that has not yet been resourced at the level the community-based model requires. Indiana's competitive integrated employment outcomes trail national benchmarks on participation, hours, and earnings, and trail most Midwest peer states, in part because supported employment accounts for only 0.3% of total IDD expenditures. he median DSP wage of $16.02 was $2.37 below the national median, with supervisory loads running 40% heavier than the national norm, underscoring substantial workforce pressure within the community service system. Nearly 60% of Indiana's caregiving families, who support roughly 73% of all Hoosiers with IDD outside the formal system, have a primary caregiver who is middle-aged or older. As those caregivers age out of their roles, the demand on the formal system will grow regardless of any other policy decision.

Conclusion. The reallocation of dollars from institutional to community settings is not a new policy direction for Indiana. It is the direction the system has been moving for four decades, and the results are documented throughout this brief. More than 113,000 Hoosiers with IDD live in their communities today. Forty-six thousand are actively supported through programs that make that possible. The question is whether Indiana sustains the investment that produced those results, at the pace required to meet the demand that is already here and the demand that is coming.

Section 1: What HCBS Is and What Indiana Has Built

Home- and community-based services, known as HCBS, are Medicaid-funded supports that allow people with intellectual and developmental disabilities (IDD) to live in the community rather than in institutions. These services include personal care, supported living, day supports, employment assistance, respite for families, and case management, delivered in homes, neighborhoods, and workplaces rather than in congregate facilities. HCBS is not a single program. It is a framework authorized under federal Medicaid law, through which states design and fund waiver programs tailored to the needs of their populations.

Indiana has been building its HCBS system deliberately for more than four decades. The investment reflects a sustained policy commitment, grounded in both values and evidence, that people with IDD live better lives and cost the public system less money when they are supported in the community rather than in institutions. The central fiscal story of Indiana's IDD system over that period is a gradual reallocation of public dollars away from expensive institutional and institutional-like settings and toward community-based services and supports that serves more people at lower per-person cost. The question facing Indiana is not whether it can afford its community-based system, but whether it can afford to slow or reverse a shift in reallocation that has been making the system more efficient, more humane, and more capable of meeting demand for four decades.

Indiana's Bureau of Disabilities Services administers four Medicaid HCBS waivers that directly serve people with IDD and related conditions:

- Community Integration and Habilitation (CIH) Waiver: serves people with the most significant support needs, providing comprehensive community-based services as an alternative to institutional care.
- Family Supports Waiver (FSW): provides services to people living with family caregivers.
- Health and Wellness (H&W) Waiver: supports people aged 59 and younger with substantial physical or medical disabilities across a range of community settings. The H&W Waiver is not limited to people with IDD and serves a broader population.
- Traumatic Brain Injury (TBI) Waiver: serves a smaller population with acquired brain injuries.

Indiana also operates the PathWays for Aging Waiver, which provides HCBS to individuals aged 60 and older with significant physical or medical support needs. PathWays is distinct from the IDD-focused waivers but connects to this brief's subject at a critical point: As caregivers of people with IDD age, they may themselves eventually need PathWays supports; when they can no longer provide care, the people they support transition into the IDD waiver system. Together these programs form the Medicaid-funded infrastructure through which Indiana delivers formal community-based supports across the disability and aging continuum.

This brief refers to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) in several sections. ICF/IIDs are a federally defined Medicaid institutional benefit that combines residential care with habilitative, health, behavioral, and related supports in certified facilities. Indiana closed its state operated institutions decades ago and does not operate state run ICF/IID facilities today. Instead, ICF/IID services are delivered through privately operated settings, most commonly small residential homes located within ordinary communities. This includes Supervised Group Living (SGL), Indiana's predominant small home ICF/IID model. Although these homes may be physically integrated into neighborhoods and can support community participation, they remain institutional services rather than HCBS. Housing and services are bundled under a single provider and payment structure, and residential, habilitative, day, transportation, nursing, behavioral, and other supports are organized through the facility. This structure can limit the separation of housing from services, portability of supports, choice among service providers, and individual control over where and with whom a person lives. It can also create more congregate and program driven routines than models in which supports are organized around an individual living in a home of their choosing. The lived experience of individual ICF/IID settings varies, but their institutional designation reflects these structural differences from HCBS, not simply the size or physical location of the residence. When this brief refers to facility based settings, congregate care, or institutional services, it is referring to these privately operated ICF/IID settings, which span a range of size, support intensity, restrictiveness, and per person cost.

Employment supports represent an important complement to the waiver system. Vocational rehabilitation (VR), a separate federal-state program administered through Indiana's Bureau of Rehabilitation Services, funds supported employment services, job placement, and pre-employment transition services for students with disabilities. Most competitive integrated employment supports in Indiana are VR-funded rather than waiver-funded. These two funding streams serve overlapping populations along a shared pathway toward community employment, and the brief draws on data that captures both.

HCBS waivers are the center of this brief, but they do not capture the full picture. The data sources drawn on here, including consumer outcome surveys, employment tracking systems, residential data, and population estimates, cover a broader population than waiver recipients alone. Most Hoosiers with IDD live with family caregivers and receive no formal waiver services at all. Their experiences, their employment outcomes, their unmet needs, and the age of their caregivers all shape the demand that Indiana's formal system must meet. Understanding HCBS requires understanding the larger context it operates within, including the people it does not yet reach.

Indiana's system is also not static. The state launched an employment initiative in 2022 to phase out subminimum wage employment through HCBS programs, reflecting a policy commitment to competitive integrated employment. A statewide waiver reset process now underway is redesigning the waiver structure to improve sustainability, simplify administration, and better align supports with assessed need. These changes are occurring within a system that is already operating near or at capacity in its most intensive programs, against a backdrop of growing demand and an aging caregiver population. This brief aims to present what this system has built, what it has not yet achieved, and what it will need to sustain.

Section 2: Who Depends on These Supports

Indiana's IDD service system operates through two distinct Medicaid structures. During the period examined, 46,709 individuals received services through Indiana's HCBS waivers, which fund supports intended to enable people with disabilities to live in homes and communities outside institutional settings. Indiana also served 2,589 individuals through Supervised Group Living (SGL), the state's predominant small-home ICF/IID model. Although SGL homes are typically located in residential neighborhoods and serve relatively small numbers of people, they are financed and regulated as institutional ICF/IID services rather than through HCBS waivers. This distinction is important because the two systems differ not only in financing, but also in how housing, services, provider choice, and individual supports are structured.

These numbers represent people receiving services. They do not represent the full population with assessed need.

As of February 2025, 8,961 Hoosiers were on the Family Supports Waiver waitlist and 4,643 were on the Health and Wellness Waiver waitlist. Combined, more than 13,600 Hoosiers have been determined eligible for waiver services and are waiting

to receive them.[1] By February 2026, the Community Integration and Habilitation Waiver had reached full capacity, with zero slots remaining.[3]

The age composition of the Family Supports Waiver waitlist is particularly significant. Nearly 78 percent of those waiting (approximately 6,800 children) are under the age of 13. This is not a backlog of recent applicants. At the end of 2024, the state was processing applications submitted in early 2022, meaning families are navigating a wait measured in years, not months.[1,2] Applications for BDS services have grown steadily over the same period, rising from 3,555 in 2020 to 8,915 in 2024, a 150 percent increase in four years. Demand is not leveling off.[2]

The gap between enrollment and waitlist numbers is the clearest available measure of unmet need in Indiana's disability service system. More than one in four people with a determined eligibility for waiver services is not receiving them.

Waiver Program	Enrolled (Feb 2025)	On Waitlist (Feb 2025)
Community Integration & Habilitation (CIH)	9,117	0 (at capacity)
Family Supports (FSW)	24,045	8,961
Health & Wellness (H&W)	13,370	4,643
Traumatic Brain Injury (TBI)	177	—
Total (all waivers + related programs)	**46,709**	**13,600+**

Source: Indiana FSSA Bureau of Disabilities Services, February 2025.[1] CIH waitlist reflects zero remaining capacity as of February 2026.[3]

Longitudinal data from the Research and Training Center on Community Living at the University of Minnesota provides historical context for the system's scale and structure in their annual Residential Information Systems Project (RISP) report. In fiscal year 2021, Indiana had 34,981 combined Medicaid waiver and ICF/IID recipients, with 92% waiver funded and 8% in ICF/IID settings. The RISP data also documented 3,153 people living with family members and waiting for Medicaid waiver funded long-term services and supports (LTSS), the full range of Medicaid-funded assistance that helps people with disabilities live in the community (as of June 30, 2021). Indiana is estimated to need approximately 9% growth in its combined system to serve everyone waiting at that time.[11] The growth in waitlist numbers since 2021, now exceeding 13,600 on the FSW and H&W waivers alone, reflects both system expansion and the accelerating pace of demand.

Section 3: What the Data Show About Outcomes

Indiana's HCBS system is producing measurable outcomes for the people it serves. Data from the 2023-24 NCI Indiana In-Person Survey (a nationally standardized consumer outcome survey administered directly to people receiving IDD services) documents meaningful community participation, strong choice indicators across several key life domains, and health outcomes that compare favorably to national benchmarks.[4] The same data identifies persistent gaps in self-determination and social connection that represent the distance between what Indiana's system currently delivers and what it is capable of producing with sustained investment.

Community participation is a core measure of whether HCBS is achieving its purpose. In Indiana, 88% of survey respondents went shopping in the past month and 88% went to a restaurant or coffee shop. Nearly three-quarters reported going out for entertainment, and Indiana outperformed the national NCI average on restaurant outings and religious participation. Its overall Community Inclusion Scale of 81% was essentially in line with the 82% national benchmark. Among those participating in community groups or organizations, 97% said they can be themselves and 96% said others include them as part of the group, both meaningfully above national averages.[4]

Choice in significant life decisions is also a strength in several domains. Among people not living in a family home, 69% chose or had input in where they live and 54% chose or had input in selecting housemates, both significantly above national averages. Indiana reports that 89% decide or get help deciding their daily schedule, 94% decide or get help with free time, and 96% of those with paid community jobs chose or had help choosing where they work.[4]

These are genuine accomplishments. They are also incomplete.

Self-determination is a foundational principle of Indiana's disability service system, and the NCI data identifies specific domains where that principle is not yet fully realized in practice. Only 77% of Indiana respondents choose or get help deciding what to buy with their own spending money, compared with 90% nationally. That 13-point gap on something as basic as personal spending reflects a meaningful constraint on everyday autonomy. Indiana's Everyday Choices Scale of 87% falls below the 90% national average, and only 53% chose their staff or knew they could request a change, compared with 60% nationally. The ability to choose who

provides your support is not a minor preference. It is central to what self-determination means in practice.[4]

Social connection tells a similar story. Indiana is below the national average on having friends who are not staff or family, at 72% versus 78% nationally. More significantly, 71% of Indiana respondents said they want help making or keeping contact with friends, well above the 55% national average. The desire for connection is present and clearly expressed. The supports to act on it are not consistently available.[4]

Unmet support needs follow a recognizable pattern. The most commonly identified additional needs were help working on job skills at 13%, help finding something different to do during the day at 10%, and staff support to help at home at 9%. Transportation, technology access, and mental or behavioral health supports were also identified. That 59% of Indiana respondents reported needing no additional supports compares favorably to the 48% national average and reflects real system progress. The 41% who do identify unmet needs, however, represent thousands of Hoosiers whose current supports fall measurably short of what they require.[4]

Health indicators are strong in several areas. All respondents report having a primary care doctor or practitioner, 82% had a routine dental exam in the past year, and only 1% reported themselves in poor health. Preventive care gaps exist, including physical exam and hearing test rates below national averages, but the overall health profile reflects a system in which people are connected to care.[4]

Indiana's community-based system is generating real, documented outcomes. The NCI data also makes clear that the work is not finished. On self-determination, social connection, and specific unmet support needs, Indiana has measurable room to improve. That improvement depends on the sustained investment that has produced the progress already documented here.

Caregiver and Family Perspective

Family and caregiver perspectives drawn from the NCI Family/Guardian and Adult Family surveys, which collect data directly from family members and guardians of people receiving IDD services, reinforce the individual survey findings while adding important texture on service delivery and long-term stability. Ninety-three percent of Indiana family and guardian respondents said services and supports are helping their family member live a good life.[5,6]

The same families, however, identify meaningful strain in how services are actually delivered. Only 80% of Indiana family and guardian respondents said their family member receives all services listed in their plan, compared with an 88% weighted

national average. That 8-point gap means that for roughly one in five families, the support package on paper is not the support package being received. Communication compounds the problem: Only 39% of Indiana respondents said staff or residential agencies always keep families informed about how their family member is doing, compared with a 46% national average.[5]

For families supporting adults at home, the formal support picture is thinner than the national average across several service types. Indiana families reported lower than average rates of state-funded in-home support, out-of-home respite, and day or employment supports, suggesting that many families are absorbing support gaps through their own time and resources.[6]

Future planning needs are a consistent concern. Indiana families identified needing help with housing planning at 44%, medical planning at 42%, financial planning at 41%, employment at 32%, and legal planning at 28%, most at or above national averages. Even families who see the current system as beneficial express uncertainty about long-term stability.[5]

Taken together, the caregiver data affirm that Indiana's HCBS system produces outcomes families value while also identifying a clear pattern of strain: services that do not always arrive as planned, communication that falls short, and futures that feel less secure than they should. Those are solvable problems. They are also problems that require the investment and system capacity that make reliable service delivery possible.

Section 4: Employment and Economic Participation

Data from the 2025 Indiana Day and Employment Services Outcomes System (DESOS) report, an annual census of day and employment service settings conducted by IIDC at Indiana University, documents where 11,325 Hoosiers with IDD spend the majority of their day and what their employment outcomes look like.[8] DESOS captures people receiving services from Indiana providers regardless of funding source, including those funded through Medicaid HCBS waivers, vocational rehabilitation, or both. Most competitive integrated employment supports in Indiana are VR-funded rather than waiver-funded, and the data reflects the full landscape rather than waiver-funded services alone.

Twenty-three percent of individuals tracked in DESOS, or 2,563 people, are in competitive integrated employment (CIE), working alongside nondisabled

coworkers for competitive wages paid by a community employer. This represents an increase from 21% in 2024. At the same time, 44% spend the majority of their day in non-employment day programs. Facility-based employment (the sheltered workshop model) now accounts for only 7% of individuals—the lowest in Indiana's recorded history.[8]

The wage data makes the stakes of that distinction concrete. Individuals in CIE, who work an average of 19 hours per week and have their paycheck issued by a community employer, earn an average of $12.35 per hour. Individuals in facility-based employment, where most workers have disabilities and wages are set by the provider rather than a community employer, work an average of 18 hours per week but earn an average of $3.68 per hour, with 86% earning below the state and federal minimum wage. That difference is not a program category distinction. It is a difference in economic participation, community membership, and the basic expectation that work is compensated fairly.[8] Among individuals in CIE, 63% engage frequently and on an ongoing basis with a variety of people, compared with 29% among those in non-employment day programs. Integrated employment is one of the most reliable pathways to the broader community connection Indiana's system is designed to support.

National data from the *StateData: National Report on Employment Services and Outcomes* (published annually by the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston and commonly known as the "ICI Bluebook") provides important context for Indiana's position but requires a careful read alongside the DESOS figures because the two sources use different denominators.[10] DESOS reports 23% of people actively receiving day and employment services in CIE. The Bluebook reports Indiana's CIE rate as 10.3% because it uses the full IDD agency caseload as its denominator, including people not receiving any day or employment services at all. The larger denominator produces a smaller rate. Both figures are accurate. They are answering different questions. The peer-state comparison below uses Bluebook figures throughout and is internally valid because all states use the same methodology.

On Bluebook measures, Indiana trails national benchmarks and most Midwest peers on CIE participation and weekly earnings, as shown in the following table. Indiana is moving in the right direction. DESOS shows CIE growing and facility-based employment at a historic low. The Bluebook places Indiana toward the lower end of its peer group on both participation and earnings. These figures are measuring different things, but the directional story is consistent: progress is real and the gap to close remains substantial.

The connection to the resource argument in this brief is direct. Day habilitation, supported employment, and community-based day services are part of the HCBS waiver service array. When waiver funding is constrained, the ability to support

State	CIE Participation Rate	Mean Weekly Earnings (VR closures)
National average	21.5%	$290
Michigan	37.0%	$292
Ohio	35.5%	$258
Wisconsin	26.6%	$221
Missouri	18.9%	$340
Indiana	**10.3%**	**$232**
Kentucky	8.0%	$269
Illinois	1.7%	$295

Source: ICI Bluebook, 2023 state profiles.[10] CIE rate reflects proportion of all people served by IDD agencies in competitive integrated employment (full agency caseload as denominator). DESOS reports Indiana's CIE rate as 23% among people actively receiving day and employment services — a different and smaller denominator. These figures are not directly comparable. Weekly earnings reflect vocational rehabilitation closures with intellectual disability. States sorted by CIE rate descending; Indiana bolded.

employment pathways is constrained with it. Supported employment accounts for only 0.3% of total IDD expenditures in Indiana, or $6.8 million, against a total system of $2.40 billion. The employment gap documented here and the resource allocation pattern documented in Section 5 are the same problem viewed from different angles.

Section 5: The Cost Picture

Indiana does not have a resource problem in its IDD service system. It has a resource allocation problem. The dollars exist. They are concentrated in the most expensive settings, serving the fewest people, producing the worst outcomes. The data across four decades of Indiana-specific and national sources tells a consistent story: institutional care costs dramatically more per person than community-based

care, and the continued concentration of spending in institutional settings is the primary fiscal constraint on Indiana's ability to serve more people. Redirecting dollars from institutional to community settings is not a cost increase. It is the same investment in the same system, allocated more efficiently.

The spending picture starts with how Indiana's total IDD investment is distributed. These figures draw on The State of the States in Intellectual and Developmental Disabilities, a 40-year longitudinal study of public IDD spending and service trends across all 50 states published by the Life Span Institute at the University of Kansas, which is the primary national source for IDD expenditure data used in this brief.[9] In fiscal year 2023, Indiana's total federal-state Medicaid IDD spending was $2.03 billion. Of that, $1.54 billion, or 76%, went to Medicaid HCBS, and $491 million, or 24%, went to Medicaid ICF/IID. At the federal level alone, Indiana received just over $1 billion in federal HCBS waiver funding compared with $323.1 million for ICF/IID, a ratio of more than 3-to-1 favoring community. That distribution reflects four decades of deliberate policy movement, and it documents what the shift toward community has already produced in fiscal terms.

The per-person cost comparison makes the reallocation stakes concrete. RISP data from fiscal year 2021 provides the cleanest system-level comparison, drawing both figures from the same dataset and the same year. Indiana's average Medicaid

Cost Comparison by Setting	Annual Cost Per Person
HCBS Waiver recipient — system-level average [11]	$25,042
Adjusted waiver cost per participant [9]	$45,700
Supported living — residential [9]	$73,600
ICF/IID recipient — system-level average [11]	$93,649
Private ICF/IID, fewer than 16 persons — residential [9]	$112,600
Large private ICF/IID, 16+ persons — residential [9]	$425,000

Sources: RISP FY 2021[11] and State of the States FY 2023.[9] RISP figures reflect total Medicaid expenditures per program recipient across all services. State of the States figures reflect residential or waiver cost per person for specific setting or program types. These measures use different methodologies and are not directly comparable to each other, but each independently supports the directional conclusion that institutional settings cost substantially more per person than community alternatives.

expenditure per ICF/IID recipient was $93,649, compared with $25,042 per waiver recipient, a nearly 4-to-1 cost differential.[11] State of the States residential setting data adds facility-level detail for FY 2023: supported living cost $73,600 per person annually, private ICF/IID facilities of fewer than 16 persons cost $112,600, and large private ICF/IID facilities of 16 or more persons cost $425,000.[9] These two sources measure different things and use different methodologies. The RISP figures reflect total system-level per-person expenditures. The State of the States figures reflect residential setting costs specifically. Both independently support the same conclusion: Institutional care costs substantially more per person than community-based alternatives at every level of comparison.

Costs also vary substantially within Indiana's ICF/IID system. In 2023, average monthly expenditures for Supervised Group Living were approximately $9,576 per person, while expenditures in Indiana's most intensive facility-based category averaged approximately $19,687 per month. Because SGL itself is an ICF/IID service, this comparison should not be interpreted as a community-versus-institutional cost comparison. Rather, it illustrates the considerable range in expenditures across different institutional service models and levels of support intensity.[1]

The waitlist implication is direct. The State of the States adjusted waiver cost per participant of $45,700 in FY 2023 is the appropriate per-person HCBS cost figure for this calculation, reflecting the full average cost of serving someone in the waiver system. Using that figure, the annualized cost of a single large ICF/IID residential placement at $425,000 could fund approximately nine community waiver participants. Using the RISP system-level ICF/IID average of $93,649, one placement could fund approximately two. In every comparison the direction is identical.[9,11] Indiana currently has more than 13,600 people waiting for waiver services.[1,3] Every institutional placement that can be transitioned to a community setting represents multiple people on that waitlist who could be served with the dollars freed up.

The efficiency of Indiana's HCBS investment has improved substantially over time even as the system expanded. The adjusted waiver cost per participant peaked at roughly $105,000 around 2009 in inflation-adjusted dollars and has since declined to $45,700 in FY 2023, as shown below.[9]

Indiana has expanded community-based enrollment substantially while reducing per-person cost in real terms over the past decade. That is the fiscal record of a reallocation that is working. The cost concentration pattern runs in the opposite direction. RISP data shows Indiana's ICF/IID settings served 8% of combined waiver and ICF/IID recipients in FY 2021 while consuming 26% of total expenditures.[11] A

quarter of all IDD spending serving fewer than one in ten recipients is the structural inefficiency that continued reallocation toward community-based care corrects.

Community services now account for 55.4% of total IDD expenditures in Indiana, or $1.33 billion, serving the largest share of the population. Supported employment

Fiscal Year	Adjusted Waiver Cost Per Participant (2023 dollars)
FY 1993	$13,700
FY 2003	$65,600
FY 2013	$74,900
FY 2023	**$45,700**

Source: State of the States Indiana profile.[9] All figures in 2023 inflation-adjusted dollars. The FY 1993 figure reflects the early period of Indiana's HCBS system when scale and service mix differed substantially from today.

accounts for only 0.3% of total spending, or $6.8 million.[9] That figure sits alongside the employment gap documented in Section 4 as evidence that the system's investment in employment outcomes has not kept pace with either the number of people who want to work or the state's own policy commitments.

The workforce dimension connects directly to cost sustainability and to the service delivery gaps that NCI family survey data identified in Section 3. Indiana's direct support professional (DSP) workforce, the frontline workers who provide daily personal care, community support, and employment assistance to people with IDD, is operating under measurable structural strain. Data from the 2024 NCI State of the Workforce survey, covering 17,547 DSPs across 170 Indiana providers, documents the current conditions.[7]

Indiana's median DSP hourly wage in 2024 was $16.02, essentially unchanged from $15.94 in 2023, and $2.37 below the national NCI median of $18.39. That gap reflects a structural wage disadvantage that affects Indiana's ability to recruit and retain the workforce on which the entire community-based system depends. Among separations with a known reason, 72.3% were voluntary, mirroring the national average of 72.1%, which means Indiana is operating within a national pattern in which the dominant form of DSP workforce loss is workers choosing to work elsewhere.[7]

Supervisory load compounds the wage pressure. Indiana averaged 14 DSPs per frontline supervisor, compared with a national NCI average of 10-to-1. A heavier span of control makes onboarding, coaching, and retention harder in a workforce already operating below the national wage benchmark. There are signs of growth in some parts of the provider system, with 39.1% of agencies reporting DSP counts increased by more than 10% over 2024, but 11.8% reported a decline of more than 10%.[7]

The cost implications of workforce strain do not appear in waiver authorization figures or institutional cost comparisons. They appear in the fact that only 80% of Indiana families confirmed their family member receives all services listed in their plan, compared with 88% nationally, meaning roughly one in five Indiana families report their family member does not receive all planned services,[5] in the 13,600 people waiting for services the system is authorized to provide but cannot always staff,[1,3] and in the downstream cost of crisis placements and family caregiver burnout when community supports fail. DSP workforce investment is not a separate budget line from HCBS sustainability. It is the same investment.

The fiscal case for continuing Indiana's reallocation toward community-based care is not complicated. Community settings cost less per person than institutional settings at every level of comparison. Per-person waiver costs have declined in real terms even as enrollment expanded. And the dollars currently concentrated in the most expensive institutional placements, if reallocated toward community-based supports, would fund services for multiple people currently waiting. The resource exists. The question is where it is directed.

Section 6: Indiana in National Context

Indiana's IDD service system does not exist in isolation. The State of the States Indiana profile, drawing on data through fiscal year 2023, provides a 40-year comparative record that situates Indiana's investment, outcomes, and population trends within the national landscape.[9] The picture that emerges is one of meaningful progress on community integration and fiscal commitment, alongside persistent gaps in employment outcomes and a demographic trajectory that will place significant new demands on the system in the years ahead.

Spending and Fiscal Effort

Indiana's total public IDD spending reached $2.40 billion in fiscal year 2023, with a fiscal effort of $5.87 per $1,000 of personal income, near a historical high for the

state. Indiana has no state-operated institutions, a distinction shared by only a small number of states nationally, and its ICF/IID spending is concentrated in smaller private facilities rather than large congregate settings. The structural shift away from institutional care across the full 40-year record is the primary story of how Indiana's IDD system became both larger and more efficient over time. States that have continued moving dollars from institutional to community settings have been able to serve more people at lower per-person cost. Indiana's trajectory reflects that same pattern, and the data are clear about the direction in which continued progress lies.[9]

Community Living

Indiana's residential data reflects the national trend toward smaller, more integrated living arrangements. The number of people in supported living settings of six or fewer persons grew from 7,514 in 2013 to 8,782 in 2023, a 17% increase over the decade. Large congregate settings of 16 or more persons held relatively steady over the same period, with nursing facilities accounting for the majority of that count. The overall direction is consistent with national deinstitutionalization trends, though Indiana's nursing facility numbers warrant continued attention as a setting that falls outside the typical HCBS framework.[9]

RISP data from fiscal year 2021 adds residential structure detail. Indiana reported 4,482 nonfamily settings serving 11,197 LTSS recipients, for an average of 2.5 people per setting. Among people in nonfamily settings, 65% lived in settings of three or fewer people and 80% lived in settings of six or fewer people.[11] That residential profile reflects a system oriented substantially toward small, community-scaled homes rather than large congregate models, a structural characteristic that supports both the quality of life outcomes documented in Section 3 and the cost efficiencies documented in Section 5.

The Scale of Family Caregiving

The State of the States data provides a figure that waiver enrollment numbers alone cannot capture. In fiscal year 2023, an estimated 113,900 Hoosiers with IDD, or approximately 73% of the total estimated IDD population, lived with a family caregiver. Only 13,400, or 9%, lived in supervised residential settings. Another 28,800, or 18%, lived alone or with a roommate.[9]

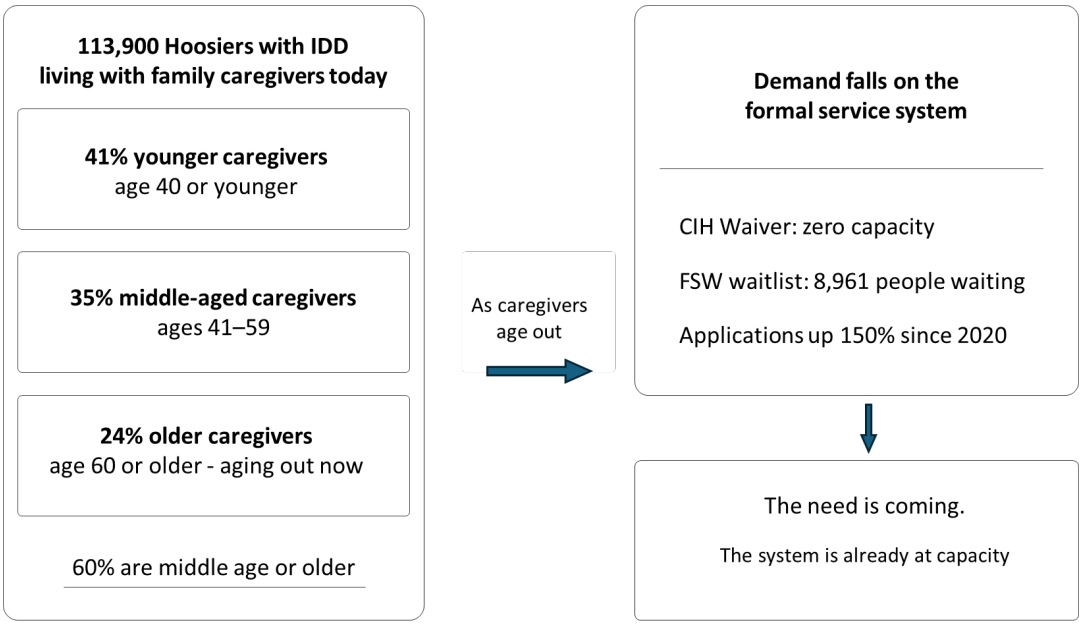
The formal service system, as large as it is, directly supports a fraction of Indiana's total IDD population. The majority of care is provided by families, largely outside the waiver system and largely without formal accounting in enrollment or spending data. The FSW waitlist figure of nearly 9,000 people documented in Section 2 represents families who have formally applied and are waiting.[1] The 113,900 living

with family caregivers represents the full scale of the informal care infrastructure that Indiana's formal system depends on.[9]

Caregiver Aging and Future Demand

The most significant forward-looking finding in the State of the States data involves the age profile of Indiana's caregiving families. In fiscal year 2023, an estimated 27,100 caregiving families, or 24% of the total, had a primary caregiver age 60 or older. Another 40,000 families, or 35%, had caregivers between ages 41 and 59. Combined, nearly 60% of Indiana families providing primary care to a family member with IDD have a caregiver who is middle-aged or older.9

This is not a future risk. It is a present condition with a predictable trajectory. As caregivers age out of their caregiving role through declining health or death, the people they support will need formal IDD services. The FSW waitlist already shows that Indiana cannot meet current demand.1 The caregiver aging data documents the scale of demand that is coming regardless of any other policy decision. It is also worth noting that aging caregivers themselves may eventually qualify for Indiana's PathWays for Aging Waiver, which provides HCBS to individuals aged 60 and older



Source: State of the States, University of Kansas, FY 2023; Indiana FSSA BDS, 2025–26

with significant physical or medical support needs. The IDD and aging service systems are connected at this transition point, and the demographic pressure runs

in both directions. Indiana had 113,900 people with IDD living with family caregivers in 2023, with 21% of those families already receiving some state IDD agency support, up from effectively zero in the late 1980s. The infrastructure that will absorb the transition of aging caregivers' family members into formal services is the same infrastructure that HCBS waivers fund.[9]

Employment Outcomes in National Context

As documented in Section 4, Indiana's competitive integrated employment outcomes trail national benchmarks across multiple measures.[8,10] The State of the States data adds longitudinal context. Indiana's supported employment participation as a share of total day and work participants has grown from 14% in 1995 to 24% in 2023, a meaningful directional gain over nearly three decades. In absolute numbers, supported employment participants grew from approximately 1,500 in the late 1990s to 3,480 in 2023. That growth reflects Indiana's 2022 employment initiative, which includes phasing out subminimum wage 14c employment through HCBS programs.[9]

The gap between Indiana's current CIE rate and the national benchmark sits within this longer trend. Indiana is moving in the right direction on employment. It is doing so from a position that lags most of its regional peers and the national average, and the pace of change relative to the scale of the population still in non-integrated settings represents the primary remaining gap between policy commitment and system reality.

The Compound Picture

Indiana has made real and documented investments in community-based IDD services over four decades. Its spending has grown, its institutional footprint has shrunk, and its per-person waiver costs have declined in real terms even as enrollment expanded. At the same time, more than 13,600 eligible Hoosiers are waiting for services, nearly 60% of caregiving families have middle-aged or older primary caregivers, and employment outcomes trail both national benchmarks and regional peers.[1,3,9]

These are not contradictory findings. They are the simultaneous reality of a system that has made genuine progress and faces genuine pressure. The data are consistent about both what Indiana has built and what sustaining it requires.

Section 7: What the Data Indicate

Indiana has been moving in a clear direction for four decades. The data assembled here document what that direction has produced, what it has not yet achieved, and what it will take to sustain the progress already made. The central finding runs through every section and every source: Indiana does not have a resource problem in its IDD service system. It has a resource allocation problem. The dollars exist. They are concentrated in the most expensive settings, serving the fewest people, at a cost per person that is several times higher than community-based alternatives. The continued reallocation of those dollars toward community care is both fiscally sound and the most effective path to sustaining the IDD system and extend its reach to the thousands of Hoosiers currently waiting.

The cost case is detailed in Section 5. In summary, Indiana's institutional segment served 8% of combined IDD recipients in fiscal year 2021 while consuming 26% of total expenditures, at nearly four times the per-person cost of community waiver services in the same dataset and the same year. Indiana has simultaneously expanded community-based enrollment and reduced per-person waiver costs in real terms over the past decade. The budget pressure in Indiana's IDD system originates in the concentration of spending in the highest-cost settings. It does not originate in the community-based system that serves the vast majority of Hoosiers.

The outcomes case is equally direct. Among Hoosiers receiving community-based services, 97% report they can be themselves in community groups, 93% of families say services help their family member live a good life, and competitive integrated employment is at its highest recorded rate. Within employment settings specifically, people in competitive integrated employment engage frequently with a variety of community members at more than twice the rate of those in facility-based day programs. These are documented results of what Indiana's community-based system is already producing, not assumptions about what it should produce.

Indiana's CIH Waiver is the sharpest piece of evidence on the question of support intensity. It is Indiana's most intensive community program, designed for people who require comprehensive, around-the-clock support and who have the most significant needs within the community-based system. It had 9,117 people enrolled and zero remaining capacity as of early 2026. The state's most intensive community program is fully subscribed, fully functioning, and serving people at the highest support levels. The argument that people with the most complex needs require institutional placement is not consistent with what Indiana's own data show about who is being served, and how, in the CIH Waiver.

The outcomes and capacity data address one common counterargument, namely that people with the most significant needs cannot be adequately served in the community. The data also speak to a second argument, that institutional settings generate local economic value that would be lost through reallocation. ICF/IID facilities provide jobs, and, in some communities, are significant local employers. That is accurate and the data do not dispute it. The relevant question is whether institutional employment is the most efficient use of public dollars to generate workforce and economic activity in a community. The same Medicaid investment that funds one ICF/IID placement at the average system cost could fund between two and nine community waiver participants, each of whom also requires direct-support staff employed in that community. More people served means more DSP positions distributed across neighborhoods, homes, and workplaces. The community-based model generates more workforce per public dollar than the institutional model.

The DSP workforce data reveal how these patterns are connected. Indiana's community DSPs earn a median wage $2.37 below the national average, with supervisory loads running 40% heavier than the national norm. Research using National Core Indicators data finds that states with higher proportions of people in individualized community settings have lower DSP turnover, and that per capita Medicaid spending is a statistically significant predictor of workforce stability.[12] The pattern in Indiana's data is consistent with this conclusion: Dollars concentrated in high-cost institutional settings are not available to fund adequate community wages and supervisory capacity. The one-in-five Indiana families reporting that their family member does not consistently receive all planned services reflects what happens when workforce investment in community settings falls short.

These findings address system-level spending patterns and population-level outcomes. The current concentration of expenditure in the institutional segment of Indiana's IDD system is not proportionate to the number of people served, the outcomes produced, or the demand that exists for community-based alternatives. Those are what the data show, and they are the basis for what the data conclude.

The direction is not in question. Indiana's data have been pointing the same way for forty years. More than 113,000 Hoosiers with IDD live in their communities today. Forty-six thousand are actively supported through programs that make that possible. Per-person waiver costs have declined even as enrollment grew. These results did not happen by accident. They are the product of deliberate, sustained investment in a model the evidence consistently supports. The question is whether the pace of that investment keeps up with the demand that is already here and the demand that is coming.

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A Note on Data Sources and Methodology

This brief draws on data sources that use different methodologies, population definitions, and reference years. Where figures from different sources appear in proximity, the following context applies.

ICF/IID cost figures. Two sources report per-person costs for ICF/IID settings and they differ. The RISP data (FY 2021) reports a statewide blended average of $93,649 per ICF/IID recipient, calculated by dividing total Medicaid ICF/IID expenditures by all ICF/IID recipients regardless of facility size. The State of the States (FY 2023) reports facility-size-specific residential costs: $112,600 for private ICF/IID under 16 persons and $425,000 for large private ICF/IID settings of 16 or more persons. The RISP blended figure is lower because Indiana's ICF/IID population is predominantly in smaller facilities, and because the sources differ in data year and cost methodology. Both figures are accurate for what they measure and are used for different analytical purposes in this brief. The reallocation argument holds independently within each source.

Data years. Section 5 and Section 6 draw on State of the States data through FY 2023 alongside BDS administrative data through early 2026. RISP data is from FY 2021. NCI survey data is from 2023-24. DESOS data is from 2025. ICI Bluebook data is from 2023. Where data years differ, the brief uses the most recent available figure for each measure and notes the source year in citations.

Nursing facilities and ICF/IIDs. The State of the States residential data includes nursing facilities in the 16 or more persons category. Nursing facilities are distinct from state-operated ICF/IIDs and serve a broader population that includes elderly residents without IDD. Indiana has no state-operated institutions. The brief's references to large congregate settings in Section 6 reflect this mixed category and should not be read as referring exclusively to IDD-specific institutional placements.

DESOS and Bluebook CIE rates. DESOS reports that 23% of people actively receiving day and employment services from Indiana providers are in competitive integrated employment. The ICI Bluebook reports Indiana's CIE rate as 10.3%. These figures differ because they use different denominators. DESOS uses people currently receiving day or employment services from Indiana providers as its denominator. The Bluebook uses the full IDD agency caseload, including people receiving a much broader range of services who are not in any day or employment setting. The larger Bluebook denominator produces a smaller rate. Both figures are accurate for what they measure. The peer state comparison in Section 4 uses Bluebook figures throughout and is internally valid because all states use the same methodology.

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