Adult Family Care: A Viable Alternative to Nursing Homes

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About this Series

This Spotlight is part of the AARP Public Policy Institute's LTSS Choices initiative. This initiative includes a series of reports, blogs, videos, podcasts, and virtual convenings that seeks to spark ideas for immediate, intermediate, and long-term options for transforming long-term services and supports (LTSS). We will explore a growing list of innovative models and evidence-based solutions—at both the national and international levels—to achieve system-wide LTSS reform.

We recognize the importance of collaborating and partnering with others across the array of sectors, disciplines, and diverse populations to truly transform and modernize the LTSS system. We invite new ideas and look forward to opportunities for collaboration.

For all questions and inquiries, please contact Susan at LTSSChoices@aarp.org.

People who require long-term services and supports (LTSS) desire access to living options other than nursing homes. Adult family care (AFC) is a term loosely describing a combination of housing and LTSS in which care recipients live full time in a house or other small residential setting. This type of care is a viable alternative to nursing homes for older adults and people with disabilities. In collaboration with health care professionals, AFC offers individuals assistance with activities of daily living (ADLs) and personal care, and help with medications and other health care tasks. AFCs provide housing, services, a caregiver workforce, and often integration with the community. AFCs serve people who pay with private resources, as well as participants of Medicaid and other home- and community-based services (HCBS) programs in some states.

More than 40 years ago, Oregon and Washington state established the first AFCs for private-pay residents and those receiving public funds. The goal, to create choices for people who prefer more homelike support in small residential settings, proved successful, and by 2009, 30 states had licensed a total of 18,901 AFC facilities with a capacity to serve 64,189 residents.[1] Today, 18 states license AFC under assisted living regulations (see appendix 1) and 38 states include AFC among the array of LTSS residential care options available.

[1]Robert Mollica et al., "Building Adult Foster Care: What States Can Do," AARP Public Policy Institute, Washington, DC, September 2009.

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Despite a long history of operating within communities, AFCs remain relatively unknown among consumers and their families. Further, in some states, the number of AFCs has remained stable or even declined over the years, even as the population ages and demand for LTSS services increases. While some states have hesitated to widely market AFCs because of difficulties in recruiting providers, this doesn't entirely explain why AFC is not more widely available. AFCs remain featured alongside other options in consumer guides and websites published by state licensing agencies. But while some state policy makers, like those in Washington and Oregon, have managed to better use their regulatory processes to support AFCs, other states have left AFC providers to fend for themselves.

Consumers, family members, advocates, and policy makers can learn more about AFC through several resources, such as state licensing agency websites, which contain information about the range of programs that help consumers. Often these licensing agencies publish consumer guides that offer detailed information about what to look for when considering AFC. State Aging and Disability Resource Centers also provide information about AFC as an option for consumers seeking LTSS.

This *Spotlight* summarizes the key features of AFCs for consumers, advocates, and state policy staff seeking to expand the number of AFC providers in their state. By highlighting several components found in state regulations on AFC, this report also provides resources for improving awareness and evaluating AFC care options.

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Introduction

State health departments, human service agencies, aging and disability agencies, and county agencies offer varying guidance on responses to the COVID-19 pandemic. The Washington State Department of Health, for example, tracks data on COVID-19 deaths and cases in all long-term care facilities, including adult family homes.[2] CDC data and data from state health department reports include assisted living facility cases, which in some states include AFC under the definition of *assisted living*.[3] See appendix 1 for information about states that cover small facilities under the assisted living licensing regulations. Multnomah County, Oregon, prepared a list of resources to prepare for and respond to COVID-19 outbreaks, including a toolkit for facilities with five or fewer residents.[4] The Massachusetts Council for AFC, a nonprofit organization representing AFC providers, posts information about COVID-19 vaccine education and outreach as well as news updates.[5]

Nursing home and assisted living residents have been tragically impacted by COVID-19, experiencing much higher case rates and more deaths than the general population. AFC cases and deaths are generally not reported separately from nursing home or assisted living counts, so it is unknown exactly how COVID-19 has impacted AFC residents and providers. However, because of their smaller size, fewer residents, and fewer paid staff going in and out on a regular basis, it is likely that AFC residents have had lower risk of infection than nursing home and assisted living residents. Assuming recommended preventive measures have been taken, AFC providers and residents essentially form an insular family unit or COVID "pod." Still, as AFC residents have the same high risks as nursing home and assisted living residents, it is important they be among the earliest populations vaccinated.

What Is Adult Family Care?

Adult family care was developed as a community residential living option for individuals with LTSS needs. There is no standard definition of AFC, but as a term it describes a combination of housing and LTSS in which care recipients live full time in a house or other small residential setting and receive hands-on services and supports from a resident family and/or other paid staff. AFC, sometimes called adult foster care or adult family homes, is often included under a state's definition of assisted living.

AFC providers assist residents with ADLs, including bathing, dressing, eating, toileting, and mobility/ambulation, as well as offer supervised care to older people and adults with disabilities. These homes generally serve one to eight residents, depending on the state and whether there is a designated AFC licensing category. Several states treat all AFC providers under assisted living rules covering providers that serve one to six residents as well as those serving seven or more. For example, providers in Florida, Iowa, and Oregon can serve up to five residents. Georgia, Maine, Michigan, Minnesota, North Carolina, and Wyoming permit up to six residents. Kansas, Louisiana, and Texas allow AFC providers to serve up to eight residents. Washington state passed legislation in 2020 that raised the maximum number of residents from six to eight.[6] The remaining states limit provider capacity to between two and four residents.

[2]For updated information on COVID-19 deaths and cases in long-term care facilities and adult family homes in Washington state, see Washington State Department of Health, *Washington State Long-Term Care Report* (2021), https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/Weekly-COVID-19-Long-Term-Care-Report.pdf.

[3]Sarah H. Yi et al., "Characterization of COVID-19 in Assisted Living Facilities—39 States, October 2020," *Morbidity and Mortality Weekly Report* 69 (2020): 1730–35, http://dx.doi.org/10.15585/mmwr.mm6946a3.

[4]The Multnomah County, Oregon, list of resources to prepare for and respond to COVID-19 outbreaks is available at https://multco.us/novel-coronavirus-covid-19/long-term-care-facilities-covid-19-guidance (2021).

[5]For information about COVID-19 in Massachusetts adult family care homes, see https://massafc.org/.

[6]Washington State Legislature, RCW 70.128.066, "Seven or Eight Bed Adult Family Homes—Requirements—Licensure," (no date), https://app.leg.wa.gov/RCW/default.aspx?cite=70.128.066.

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Many AFC providers started out by providing care in their home to a family member, and then began caring for a second, nonrelative older adult. These "mom and pop" providers live in the home and independently manage the AFC. Other AFC providers operate multiple sites, with a site manager and staff at each location.

AFCs often help residents become more integrated into their communities. Providers may bring them to religious services and other community events. They often invite visitors to the home and include residents in their own family events. Providers may have other family members living with them, including children, who have their friends come to visit. Hence, AFCs are more homelike.

How Is Adult Family Care Regulated?

States use three different approaches to regulate AFC: licensing/certification requirements, state Medicaid standards, and assisted living regulations. States that use assisted living regulations to license small AFCs may not always reflect the differences between operating a facility for three or four residents versus one that serves a larger number of residents. States design licensing and certification requirements specifically for small residential settings or for all residential settings with the capacity to serve more than a specified number of residents. States typically license providers, although a few states certify them. Licensing rules are usually more extensive than certification standards, and licensed facilities may receive more oversight and monitoring (see appendix 1).

Key Features

There are several key features to understand when looking at AFC: admission/retention and acuity policy, resident agreements, staffing and training standards, and medication administration and oversight.

Admission/Retention and Acuity

State regulations typically specify the service needs and conditions of residents. These provisions are designed to protect the health and welfare of residents whose needs exceed the services that licensed AFCs may provide. AFC is often a "bounded choice" under state regulations, in that parameters define the level of need that providers may address in these settings. State rules set expectations and requirements in licensing rules and the AFCs decide whether they can meet residents' needs. For example, the Washington state licensing agency does not limit resident acuity levels that an AFC provider can accept. However, providers are responsible for meeting the needs of residents they admit. If providers cannot meet the needs of higher-acuity residents, they risk licensing actions. Those who are interested in becoming AFC providers need to consider whether they can meet residents' needs.

While state regulations establish the criteria and set the parameters within which operators may serve residents, operators may decide to serve lower-acuity residents. AFC providers that accept Medicaid HCBS waiver participants agree to serve residents who meet at least the minimum qualifications for nursing home care. Each state sets its own criteria for admission to a nursing home and, as a result, the minimum requirements vary from needing assistance with ADLs to requiring treatment for a health condition. Admissions criteria can be general or specific. Alabama, Delaware, Idaho, Indiana, Kentucky, Virginia, and West Virginia describe the residents that providers may serve in general terms and frequently reference the provider's ability to meet each resident's needs. For example, Alabama allows providers to serve adults who need protective services and cannot live in their own homes. Residents in Delaware must be able to perform all ADLs without assistance at the time of admission, but the rules allow residents to age in place and receive added services over time.

AFC homes in three states (Maine, Minnesota, and Wisconsin) submit to the licensing agency a description of the residents they will serve. Minnesota's rules do not contain specific admissions or retention criteria. Operators submit a plan that describes the type of

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functionally impaired adults they will serve. Florida, Iowa, Kansas, Mississippi, New Hampshire, New York, and Wyoming prohibit homes from serving residents with specific conditions.[7] Oversight of the extent AFCs are meeting resident needs varies by state.

Resident Agreements

Before choosing to move into an AFC home, prospective residents should obtain information about services, costs, discharge and transfer policies, and other terms and considerations (e.g., terms of occupancy, house policies). Thirty-nine states require resident agreements that describe the arrangement between the AFC provider and the resident. These contracts are also required in most states with assisted living facilities. Items included in the agreement are not standardized across states, but generally cover admission policies, services that AFC operators will provide to the resident, charges, resident rights, and other expectations and obligations of the resident and the provider (see appendix 2).

Staffing and Training Standards

Staffing is a critical element in AFC. State regulations usually require that providers have sufficient staff available to provide 24-hour supervision and to meet the needs of residents. For example, providers in Georgia and Montana must have someone onsite at all times. Indiana and New York require that AFC providers live in the home.

Training is another important element. Training increases provider knowledge and skills to improve the level of care provided to residents. States use an array of AFC training approaches, ranging from simple overviews of licensure to operational and business training for providers. AFC staff in Washington state must complete a 75-hour training program and administrators must complete a 54-hour training program.[8] The administrator course addresses the basics of operating a small business. The state instituted this requirement in response to the number of homes that fail in the first year due to small business management challenges rather than resident care issues.

Most states require a background check of all AFC providers, although the scope of screening and whether all family members living in the home are required to undergo a background check varies by state. In Oregon, all AFC providers and primary caregivers must pass some level of background check, complete a basic training course and pass an exam, be physically and mentally able to provide care, and provide that care in a home that meets structural and safety requirements. A study guide is available from the Oregon Department of Human Services to help applicants understand the responsibilities of AFC providers.[9] In Florida, a Level 2 state and national fingerprint-based criminal background check is required for all AFCs, including the provider, the designated relief person, and all adult household members.[10]

Information about the extent to which state oversight identifies and addresses quality issues in AFC is not reported nationally, although individual states may post survey reports on their website.

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[7] Conditions typically listed in the regulations include skilled needs, bedbound, part-time or intermittent nursing services, stage 3 or 4 pressure sores, residents who are a danger to themselves or others, and residents who require chemical restraints.

[8] More information on adult family home training in Washington is available at https://www.dshs.wa.gov/altsa/training/training-requirements-adult-family-homes.

[9] More information about becoming an AFC provider in Oregon is available at https://www.oregon.gov/dhs/providers-partners/licensing/APD-AFH/Pages/index.aspx and https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de9030.pdf?CFGRIDKEY=DHS%25209030%2c9030%2cAdult%2520Foster%2520Home%2520Caregiver%2520Preparatory%2520Training%2520-%2520A%2520Study%2520Guide%2c%2cDE9030.pdf%2c%2c%2c%2c%2c%2chttps://apps.state.or.us/cf1/DHSforms/Fo.

[10] A Level 2 background check for adult family care homes is required by the Florida Agency for Health Care Administration under Fla. Stat. § 429.67 (2020). The statute specifies that the agency shall require Level 2 background screening for personnel, as required in Fla. Stat. § 408.809(1)(e) (2020).

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Medication Administration and Oversight

States license nursing professionals through Nurse Practice Acts (NPAs). These laws restrict unlicensed assistive staff from providing nursing care, but they sometimes allow unlicensed staff to assist with medications and other frequent health maintenance tasks. For AFC residents with stable chronic conditions, it may not be necessary to have a nurse perform health maintenance tasks, though nursing oversight may be beneficial.

Nurse delegation laws allow nurses to delegate specific tasks to unlicensed AFC staff after the nurse performs an assessment of the resident's condition and, if necessary, confirms the ability of the AFC provider to perform specific health-related tasks, usually medication administration. The ability to administer medications may determine whether an AFC provider can serve residents with higher needs.

Advocates can explore the scope of NPAs[11] to understand whether and how they apply to AFCs in their state.

Medicaid Payment Methods

State Medicaid programs typically use one of five methods to pay providers: flat rates, tiered rates, case mix rates, payments based on a care plan, and negotiated rates. Rates that vary depending on the assessed care needs of the resident create incentives for providers to continue to serve residents as their care needs increase. Tiered payments typically include three to five payment levels; case mix rates use multiple payment levels. Flat rates may be higher than necessary for residents with few needs and too low for those with many needs.

Payment methods used in Oregon, Connecticut, and Washington state are examples of different Medicaid payment methods. As shown in table 1, providers in Oregon receive a base rate for Medicaid-eligible Oregonians plus additional amounts for "add-on" services related to ADLs, behavioral health, and complex medical conditions.[12] In addition to the service payment, providers receive $608 monthly per resident supplemental security income for room and board.

Table 1. Oregon Medicaid Payment Rates

Tier	Rate
Base rate	$1,799
1 add-on	$2,126
2 add-ons	$2,453
3 add-ons	$2,780

Rates in Washington state vary by county and the care recipient's assessed level of need. There are 17 rate tiers based on level of acuity. Acuity is determined by an algorithm derived from an automated assessment tool that generates a classification group based on individual clinical factors. The tiers range from $85.24 to $192.07 per day in King County, which is the most populated county in the state and includes Seattle. Rates in metropolitan counties range from $82.75 to $185.65 and from $80.25 to $175.84 in nonmetropolitan counties.

Connecticut's AFC program has four levels of Adult family living/foster care service that are available under the program:

LEVEL 1: Services provided to individuals who, because of their disabilities, require supervision on a daily basis and require cueing or supervision to perform activities of daily living and who may also require management of cognitive or behavioral challenges are reimbursed at a rate of $42.58 per day.

[11] For more information, see www.ncsbn.org/npa.htm.

[12] See https://www.oregon.gov/dhs/PROVIDERS-PARTNERS/LICENSING/APD-AFH/Documents/AFH%20Add-on%20Criteria%2031717.pdf.

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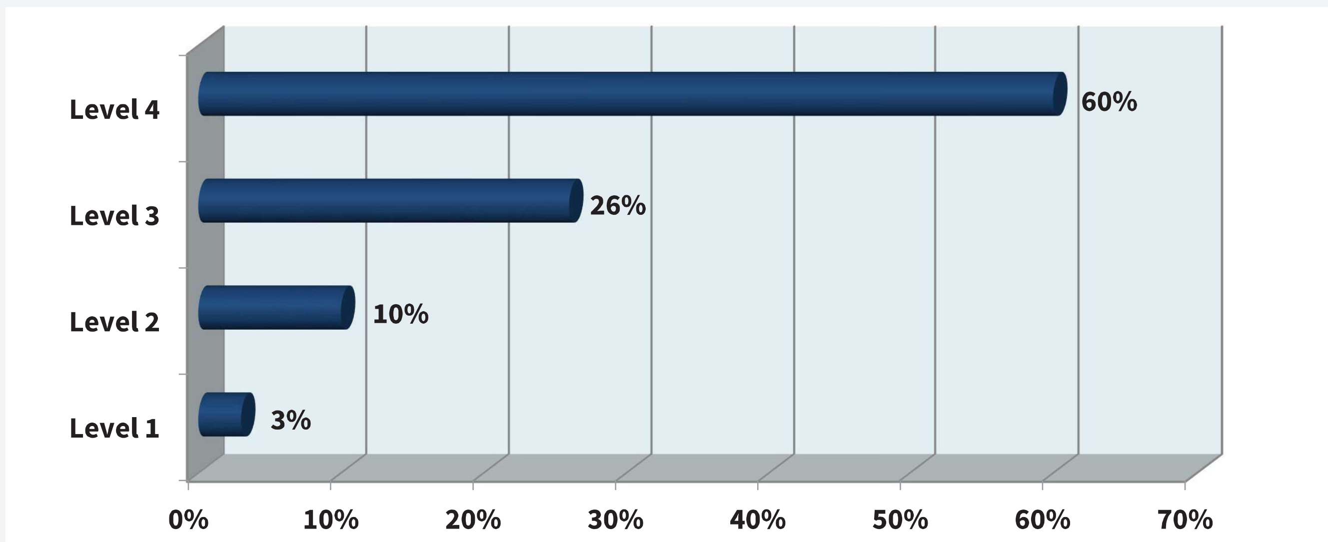
LEVEL 2: Services provided to individuals who require hands-on assistance with two or more activities of daily living on a daily basis are reimbursed at a rate of $63.40 per day.

LEVEL 3: Services provided to individuals who require hands-on assistance to perform three or more activities of daily living or two activities of daily living and assistance for the management of co-occurring challenging behaviors or cognitive deficits are reimbursed at a rate of $77.28 per day.

LEVEL 4: Services provided to individuals who require hands-on assistance to perform four or more activities of daily living or three activities of daily living and assistance for the management of challenging co-occurring behaviors or cognitive deficits are reimbursed at a rate of $107.06 per day.

As shown in figure 1, 60 percent of Connecticut's 1,598 AFC participants were assessed at the level 4 payment tier as of September 2020.[13]

Figure 1. *Percentage of Participants in Connecticut Adult Family Care/Foster Care by Payment Level, September 2020*



Private-Pay Providers

Oregon is one state with reimbursement requirements for AFCs serving private-pay residents. All AFCs in Oregon that serve private-pay consumers must have a contract with the resident. The contract must include the following:

- Basic monthly rate, which includes the basic services to be provided (room, meals, laundry, and other specified care and services), the home's refund policy, and conditions under which the rate may change
- Restrictions on the use of alcohol, tobacco, and legal medical marijuana
- Policy on pets, dietary restrictions, religious preferences, visiting hours, and additional fees (such as storage or to hold a bed)
- Cost of optional services such as incontinence care, assistance with eating, diabetic care, special diets, transportation, mobility and transfers, and skilled nursing tasks; night-time care and dementia care must also be included

[13] Personal communication with Connecticut Adult Family Living Program staff, Hartford, Connecticut, October 2020.

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Expanding the Supply

Several states are concerned that the supply of providers is limited and is declining. States that license AFC providers generally do not market the program to the public or to providers, yet doing so could help promote AFC as a viable alternative to nursing home care. The supply of AFCs in Florida declined from 491 in 2008 to 301 in 2020. Among the reasons that the licensing agency attributed for the decline are the following: fewer people were interested in this service; the site managers experienced declining personal health, or they needed to take care of a family member or focus on themselves; landlords wanted to sell the homes; and some providers died. Low Medicaid reimbursement rates, difficulty finding a "champion" among state officials, and an exodus of providers into the assisted living market are other reasons for the decline.

Oregon and Washington states have stood out for not seeing the same decline in AFCs. The supply of AFCs in Oregon has remained stable over the past decade. In Washington, the number of AFCs has soared. Both states offer insight into how other states may improve their efforts to establish strong, supported AFC programs.

In Oregon there were 1,735 AFCs in 2008[14] and 1,740 in 2017.[15] Oregon revised its reimbursement rates to increase provider willingness to serve Medicaid beneficiaries. Oregon now bases its Medicaid rates on the private-pay population. A 2017 survey of providers found that 23 percent of the respondents used a flat monthly rate, 27 percent charged a base rate plus fees for specific services, 19 percent used a monthly rate based on care needs, and 3 percent negotiated the rate with consumers.[16] Oregon hired a full-time employee to work on recruitment, using innovative venues such as Craigslist and personal ads to recruit AFC providers. State agency staff planned to offer training sessions to improve quality and retain current providers. State officials created online training modules and self-training manuals to address the needs of providers in rural areas and those who do not have time to attend onsite sessions. The 2017 study found that, on average, providers held an AFC license for 11.7 years, with a range of 1 to 30 years. A consumer guide is available on the Seniors and People with Disabilities website.[17] The guide includes a resident's bill of rights, situations that indicate when AFC might be an appropriate option for consumers, the services available in AFC, the care planning process, public information available about individual providers, suggestions for visiting providers to learn about the ambiance, and questions to ask providers and other recommendations for choosing a provider.

In the past five years, the number of licensed AFCs has increased significantly in Washington state. The Aging and Long-Term Supports Administration (ALTSA) in the state implemented a strategy that screened out individuals who did not fully understand what it meant to become a provider. As a result of these initiatives, ALTSA increased the provider supply by 19 percent, from 2,746 providers in July 2015 to 3,275 in July 2020. In addition, bed capacity has increased 21 percent, from 15,273 in 2015 to 18,536 in 2020. Eighty-nine percent of the beds in licensed providers' homes contract to serve Medicaid beneficiaries. However, 60 percent of the actual adult family home (AFH) residents in Washington state are Medicaid beneficiaries.[18] See figures 2 and 3.

ALTSA achieved the increase through an outreach and recruitment effort to reduce the turnover rate among providers. Individuals considering becoming an AFH provider must complete a one-day class to get an overview of the program and the

[14]Updated November 2020 from Mollica et al., "Building Adult Foster Care."

[15]Paula C. Carder et al., "Adult Foster Care Resident and Community Characteristics Report," Portland State University, Institute on Aging, Portland, OR, Spring 2017, https://www.pdx.edu/institute-on-aging/sites/g/files/znldhr3046/files/2020-07/2017_CBC_AnnualReport_AFH.pdf.

[16]Ibid.

[17]See https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de9033.pdf.

[18]Personal communication with Aging and Long-Term Support Administration staff, Lacey, Washington, October 2020.

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Figure 2. *Number of Licensed and Medicaid Contracted Adult Family Care Homes in Washington, 2015–20*

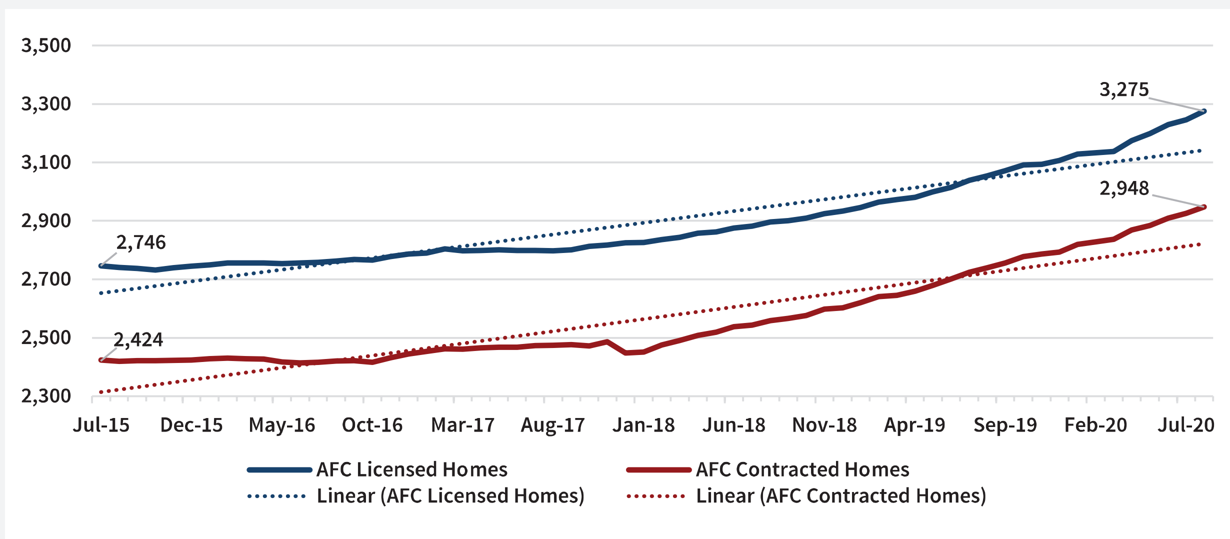
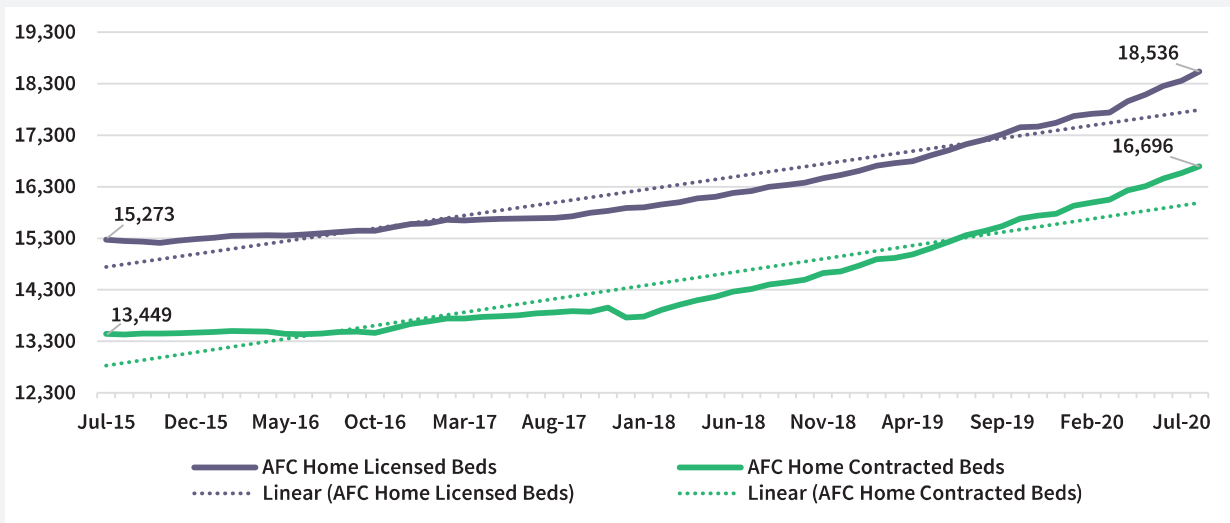


Figure 3. *Number of Licensed and Contracted Beds in Adult Family Care Homes in Washington State, 2015–20*



expectations of licensees to provide services to residents. The class screens out individuals who are not fully aware of the demands of becoming a provider. ALTSA staff indicated that thousands of people attend the six-hour preapplication training program. Of those individuals, only a fraction actually apply, which helps avoid high turnover rates among providers.

Orientation sessions are held at six colleges throughout Washington state. The number of colleges hosting the training and the number of sessions at each college expand every three years. ALTSA also initiated a marketing and orientation program to recruit providers in rural areas of the state.

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Potential providers in Washington state learn how to determine whether there is a market for the service in their area, how to balance public- and private-pay residents to produce sufficient revenues to maintain the business, and what services they need to deliver. State staff suggest that potential providers interview possible sources of referrals (e.g., discharge planners, HCBS case managers, community- and faith-based organizations that serve older adults) to estimate the potential demand and determine the right case mix of residents. The orientation session emphasizes strategic decisions that must be made to determine if the business is viable, such as whether there is a market, how many residents the market will support, and what payer and acuity mix is needed to sustain the AFH.

Potential applicants learn about the state's long-term care system, the role of adult family homes, and the characteristics of older adults served in these settings. Services and supports for ADLs and other services (e.g., meals, housekeeping, transportation, access to health and medical services, 24-hour security and staff availability, medication management, personal laundry services, social and recreational services) are presented. The licensing process, requirements, and provider standards are also described. The agenda also includes presentations from a mortgage broker who specializes in AFH loans to discuss the financing options, while a consultant reviews the administrative, property, and staffing costs of serving residents in relation to Medicaid payment rates.

Washington also developed a tool with checklists covering information consumers can use to make an informed decision. The consumer guide applies to AFC and assisted living facilities.[19]

States can also highlight the federal incentives to become an AFC provider. The Internal Revenue Service allows AFC providers to exclude payments for services from their income for up to five residents.[20] Officials in Wisconsin use the tax break to promote AFC. Many states use the Internet to recruit providers and increase awareness of adult family care among consumers.

The following recommendations might expand the use of AFCs:[21]

Provider Recruitment, Screening, and Licensing

- Develop a proactive recruitment process for AFC providers.
- Develop a systematic, objective mechanism to screen AFC provider applicants for licensure.
- Develop strategies to ensure that providers can meet the needs of AFC residents by offering training on resident needs.
- Consider specialized licensing to address the needs of special populations and residents with higher acuity.
- Recruit registered nurses to become AFC providers.
- Implement training programs for providers, resident managers, and family caregivers as a state service within an AFC program.

Consumer Awareness and Resource Tools

- Educate consumers by developing a consumer guide to AFC.
- Review the training protocol for Aging and Disability Resource Centers on information about AFC and enhance where necessary.
- Create a uniform disclosure form to provide consumers with comparable information among providers on services and rates.

[19] Available at https://www.dshs.wa.gov/sites/default/files/publications/documents/22-707.pdf.

[20] Foster Care Payments, 26 U.S.C. § 131 (2011), https://www.govinfo.gov/app/details/USCODE-2011-title26/USCODE-2011-title26-subtitleA-chap1-subchapB-partIII-sec131/context.

[21] These recommendations were included in Mollica et al., "Building Adult Foster Care."

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Case Management and Provider Resources

- Develop clear nurse delegation policies to support the ability of AFCs to provide care to residents. Possible strategies include using contract nurses or embedding nursing in the AFC Medicaid program to provide clinical assistance to providers. Better training, consulting, and oversight by nurses can improve the viability of an AFC as a service delivery model.
- Provide respite personnel or substitute caregivers for AFC providers and resident managers.

Financial Assistance and Reimbursement

- Consider targeted financial assistance for AFC providers and other small HCBS providers.
- Consider developing a tiered reimbursement rate system that varies provider payments based on residents' needs. These systems increase the payment for higher-acuity residents and decrease the payment for lower-acuity residents.

Conclusion

AFCs deserve a closer look by aging consumers looking for comfortable, supportive environments, and by policy makers and advocates seeking viable alternatives to nursing homes. There are clear steps policy makers can take to improve the success of AFCs in their communities. These steps involve a closer examination of the licensing and oversight procedures, as well as the payment structures that allow consumers to access the LTSS needed in a small, homelike residential setting.

Washington and Oregon, which have long led the way in developing and promoting AFCs, provide a clear roadmap for using the regulatory process to encourage the growth and acceptance of AFC facilities. A common thread in both states is the creation of targeted tools and resources for providers and consumers that address the financial complexities as well as the case management aspects of caring for those in need of LTSS. Revising reimbursement rates to encourage a willingness to serve Medicaid beneficiaries, stronger screening processes for potential providers, and consumer guides can help the advancement of successful, viable homelike care for those in need of LTSS.

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Appendix 1. State Approaches to AFC Regulation

State	Terminology	License/ Certify AFC	Medicaid Standards	Assisted Living Rules	Capacity
Alabama	Adult foster care	●			Not specified
Alaska	Assisted living home			●	3+
Arizona	Adult foster care	●			1–4
Arkansas	Adult family home				1–3
California	Residential care facilities for the elderly			●	Not specified
Colorado	Assisted living residence			●	3+
Connecticut	Adult family living	●			Not specified
Delaware	Family care rest home	●			2–3
District of Columbia	Community residence facility			●	1+
Florida	Adult family care home	●			1–5
Georgia	Personal care home			●	2–6
Hawaii	Adult residential care home	●		●	1–5
Idaho	Certified family home	●			1–4
Illinois	Assisted living establishment			●	3+
Indiana	Adult family care				1–4
Iowa	Elder group home	●			3–5
Kansas	Home plus	●			1–8
Kentucky	Family care home	●			1–3
Louisiana	Personal care home			●	2–8
Maine	Residential care facility			●	3–6
Maryland	Assisted living program			●	Not specified
Massachusetts	Adult foster care		●		1–3
Michigan	Adult foster care family home	●			1–6

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State	Terminology	License/ Certify AFC	Medicaid Standards	Assisted Living Rules	Capacity
Minnesota	Adult foster care	●			1–6
Mississippi	Adult foster care facility	●			Not specified
Missouri	Assisted living facility			●	3+
Montana	Adult foster home	●			1–4
Nebraska	Adult family home	●			1–3
Nevada	Home for individual residential care	●			1–2
New Hampshire	Adult family care residence	●			1–2
New Jersey	Adult family care				N/A
New Mexico	Adult residential care facility			●	2+
New York	Adult care facility	●			1–4
North Carolina	Family care homes			●	2–6
North Dakota	Family foster home		●		1–4
Ohio	Residential care facilities			●	3+
Oklahoma	Assisted living center			●	2+
Oregon	Adult foster home	●			1–5
Pennsylvania	Domiciliary	●			1–3
Rhode Island	Assisted living residence			●	2+
South Carolina	Community residential care facility			●	2+
South Dakota	Adult foster care community living home	●			1–4
Tennessee	Family home for adults				N/A
Texas	Adult foster care home	●	●		1–8
Utah	Adult foster care				N/A
Vermont	Assisted living residence			●	3+

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State	Terminology	License/ Certify AFC	Medicaid Standards	Assisted Living Rules	Capacity
Virginia	Adult foster care	●			1–3
Washington	Adult family home	●			2–8
West Virginia	Health care home	●			1–3
Wisconsin	Adult family home—certified; licensed	●			1–2; 3–4
Wyoming	Adult foster care				N/A

NOTES: Arizona, **Idaho**, **Nebraska**, **New York**, and **Ohio** certify adult foster homes.

Alabama: Adult foster care operates as a protective services program; providers must meet "minimum standards."

Alaska: Licensing is voluntary for homes serving one to two residents.

Arkansas: Medicaid standards are no longer in effect.

District of Columbia: The District also licenses assisted living residences.

Illinois: The state also licenses shared housing establishments serving 16 or fewer individuals.

Indiana: A moratorium is in place; the program is being revised to provide more oversight.

Louisiana: Personal care homes are a subcategory of adult residential care homes.

Maine: Licensing is voluntary for homes serving one to two residents.

New Jersey: Licensing rules and program information are no longer posted.

North Carolina: Family care homes are a subcategory of adult care homes.

Tennessee: AFC is a resource for Adult Protective Services participants; the state operates a "program," and none of the categories in the table apply.

Texas: Homes with one to three residents must comply with Medicaid provider standards; homes serving four to eight residents must meet licensing standards.

Utah: The program was phased out.

Wisconsin: The state certifies homes serving one to two residents and licenses homes serving three to four residents.

Wyoming: The pilot program was discontinued.

SOURCE: Updated November 2020 from Robert Mollica et al., "Building Adult Foster Care: What States Can Do," AARP Public Policy Institute, Washington, DC, September 2009.

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Appendix 2. Resident Agreement Provisions *(all licensing categories)*

State	Accommodations	Terms of Occupancy	House Rules	Admissions Policy	Grievance Process	Resident Rights	Rate Changes	Services with Added Cost	Refund/Deposits	Discharge/ Termination/Transfers	Services Covered by Basic Rate	Charges/Fees	Other	Not Required, Not Specified
Alabama								●				●	●	
Alaska		●					●		●	●	●	●		
Arizona					●	●		●	●		●	●	●	
Arkansas														●
California	●							●	●	●	●	●	●	
Colorado			●	●	●			●	●	●	●	●	●	
Connecticut														●
Delaware								●			●	●		
District of Columbia	●				●	●	●			●	●		●	
Florida	●						●	●	●	●	●	●	●	
Georgia			●				●	●	●			●	●	
Hawaii							●				●	●	●	
Idaho									●	●		●	●	
Illinois		●		●	●	●	●	●	●	●	●	●	●	
Indiana														
Iowa		●		●	●	●	●	●	●	●	●	●	●	
Kansas											●		●	
Kentucky		●												
Louisiana			●	●			●	●		●	●	●	●	
Maine	●			●		●	●				●	●		

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State	Accommodations	Terms of Occupancy	House Rules	Admissions Policy	Grievance Process	Resident Rights	Rate Changes	Services with Added Cost	Refund/Deposits	Discharge/ Termination/Transfers	Services Covered by Basic Rate	Charges/Fees	Other	Not Required, Not Specified
Maryland		●		●	●	●				●	●		●	
Massachusetts													●	
Michigan								●			●	●		
Minnesota											●	●	●	
Mississippi									●		●	●	●	
Missouri								●	●	●	●	●	●	
Montana								●				●		
Nebraska													●	
Nevada								●				●		
New Hampshire			●								●	●	●	
New Jersey														
New Mexico										●	●	●	●	
New York									●		●	●	●	
North Carolina	●		●		●	●		●		●	●	●	●	
North Dakota			●										●	
Ohio						●			●			●	●	
Oklahoma				●	●	●				●	●		●	
Oregon						●	●		●	●	●	●	●	
Pennsylvania			●									●	●	
Rhode Island			●	●	●	●	●	●	●	●	●	●	●	
South Carolina					●	●	●			●	●	●		

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State	Accommodations	Terms of Occupancy	House Rules	Admissions Policy	Grievance Process	Resident Rights	Rate Changes	Services with Added Cost	Refund/Deposits	Discharge/ Termination/Transfers	Services Covered by Basic Rate	Charges/Fees	Other	Not Required, Not Specified
South Dakota														●
Tennessee														
Texas					●	●				●	●	●		
Utah														
Vermont							●		●	●	●	●	●	
Virginia														●
Washington			●			●	●	●	●	●	●	●	●	
West Virginia												●		
Wisconsin					●	●			●	●	●	●		
Wyoming														

NOTES: In some states, resident agreement provisions are not specified.

Indiana: The program is being restructured.

New Jersey: No information is available.

Tennessee: AFC is a resource for protective services clients.

Utah: The program was phased out.

Wyoming: The pilot program was discontinued.

SOURCE: Updated November 2020 from Robert Mollica et al., “Building Adult Foster Care: What States Can Do,” AARP Public Policy Institute, Washington, DC, September 2009.

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