GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Washington, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2025

Authors
Eden Wetzel
Maya Fransz-Myers
David Knapp

Contributors
Jinkook Lee
Drystan Phillips
Kanghong Shao
Judith Solomon

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Washington, USA

In-Kind Benefits

Plan details 1992-2025 * †

Public long-term care (LTC) benefits in Washington are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Washington, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Washington's Medicaid LTC system has been subject to 2 major policy reforms: the implementation of the new, standardized Comprehensive Assessment Reporting Evaluation (CARE) in 2003, and policy changes as a result of the Affordable Care Act in 2014, including Medicaid expansion to cover individuals with incomes up to 138% of the federal poverty level (FPL) and the implementation of the Community First Choice (CFC) home and community-based services program.

Key Dates

First law: 1965

Major changes since 1992: 2003, 2014

Contents

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† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2002

Overview

Long-term care (LTC) benefits in Washington are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Washington is administered at the state level by the Washington Department of Social and Health Services (DSHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Washington are mostly provided through state plan benefit programs (Medicaid Personal Care - MPC, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Community Options Program Entry System - COPES).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. MPC provides home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COPES are also able to receive a variety of LTC benefits if deemed medically eligible, such as home health services. Those applying for COPES are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. MPC requires the individual to have a medical necessity for services, while Nursing Facility and COPES beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Policy changes during this period:

- (1993) The look back period increased from 30 to 36 months for all assets, and increased to 60 months for a trust (WAC § 388-95-395, 1993).
- (1996) COPES updates the care needs requirements to meet an NFLOC with additional eligibility pathways. The *Care Needs Assessment* section of this policy period (chapter) details these requirements.
- (1996) COPES removed case management from the list of covered services and added Personal Emergency Response System and night support services to the list of covered services (WAC § 388-15-620, 1996).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least 5 years after immigration (U.S. Congress, 1996).
- (2001) Washington state legislation updated the needs-based eligibility requirements for nursing facility care and COPES (WAC § 388-71-0435, 2001). The *Care Needs Assessment* section of this policy period (chapter) details these requirements.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025d)

Washington Law for Medicaid

- Washington Administrative Code (WAC), Chapter 388 (1992, 1993, 1996, 1997a, 1997b, 2001, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2014b, 2016, 2025c, 2025d)
- Washington Administrative Code (WAC), Chapter 182 (2014a, 2024, 2025a, 2025b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Washington Medicaid spending on beneficiaries in fiscal year 1992 was 54.98%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Washington Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Washington.

Eligibility for Medicaid in Washington for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2025a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (WAC § 388-95, 1992). This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999). See Box 1 for a list of included and excluded resources.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (WAC § 388-92-043, 1992).[2]
  - Citizenship/immigration requirements (SSA, 1998): The applicant must be a Washington resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a Washington resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2025b) for additional information.[4]
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1992, this was $1,266 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or participating in COPES and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards (WAC § 388-95-400, 1992).
  - Asset requirements: Resources may not exceed $2,000 for an individual (WAC § 388-95-390, 1992). Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards

exist when a person is institutionalized and has a spouse residing in the community.[7] See Table 3 for historical monthly spousal disregards.
    - Asset transfer: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be receiving or in need of LTC services through nursing facility care or COPES.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, institutionalized individuals must "spend down" their excess income over a 3-month or 6-month period to be equal or less than the medically needy income limit. In 1992, this was $458 per month for an individual and $575 per month for a couple (WAC § 388-99-020, 1992). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple, plus $50 for each additional family member in the household (WAC § 388-99-035, 1992).[7]
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]
    - Individuals participating in COPES may not qualify for Medicaid under this eligibility track, and must meet the requirements for track 1a or 2a.

Other Eligibility Tracks
There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Medicaid Personal Care (MPC), Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program Entry System (COPES)
Beyond meeting minimum level of dependence requirements, individuals must be at least age 65 or between age 18-64 and disabled (Medicaid.gov, 2025).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult day health
- Adult foster care
- Chore services
- Home Health[8]
- Private duty nursing
- Program of All-inclusive Care for the Elderly (PACE) —from 1995
- Medically Needy Residential Program —from 2002

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC
MPC provides personal care services, which include (WAC § 388-15-830, 1992):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Nursing Facility Care

Nursing facility care does not provide home care.

COPES

COPES provides the following home care services (WAC § 388-15-620, 1992; WAC § 388-15-620, 1996):

- Home Health, which includes the following services provided above the amount, scope, and duration of state plan home health benefits:[8], [9]
  - Skilled nursing services: Medication administration, wound care such as debridement that would require authorization, prescription and supervision provided by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse
  - Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care
- Personal care services: As described above under MPC

COPES will only cover home health services if the beneficiary needs congregate care, adult family home services, or requires personal care (WAC § 388-15-620, 1992).

From 1996, COPES home care services may be provided to individuals residing in adult residential care facilities, assisted living facilities, and adult family homes (WAC § 388-15-620, 1996).

Community care

Community care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC, Nursing Facility Care

These programs do not provide community care.

COPES

COPES provides adult day health care (ADHC), which provides center-based daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAC § 388-15-620, 1992; WAC § 388-15-620, 1996; Medicaid.gov, 2025).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC, COPES

These programs do not provide residential care.

Nursing Facility Care

Washington Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; WAC § 388-88, 1992; WAC § 388-97, 2003). Services may include the following:

- Physician services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Community care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Washington's largest home and community-based services (HCBS) program.

Washington Medicaid provides additional state plan benefits related to LTC (WAC § 388-15, 1992):

- Durable medical equipment: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services[8]
- Hospice: Care is available to residents of nursing facilities if that nursing facility is serviced by a hospice provider

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COPES

The COPES program provides the following services in addition to those offered under the state plan, unless otherwise noted (WAC § 388-15-620, 1992; WAC § 388-15-620, 1996):

- Case management (until 1996): Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-Delivered Meals: Planning, preparation and delivery of 1 meal per day to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance
- Home/Environmental Modification: Special modifications or improvements to a beneficiary's home to promote independence, prevent institutionalization, and ensure the individual's health and safety
- Personal Emergency Response System (PERS) (from 1996): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Night support services (from 1996): Assistance needed during night hours due to individual having care needs that cause them to be unable to be alone at night, prevent their primary caregiver from sleeping at least 5 uninterrupted hours a night, or who have no family or other household members who can provide this service (WAC § 388-15-620, 1996)
- Client training: Service provided to assist participants in achieving specific therapeutic goals including adjusting serious impairments, managing personal care needs, or developing skills necessary to deal with care providers
- Transportation: Assistance and escort of participant to non-medical appointments and community outings

Additionally, COPES covers medication administration services provided by licensed nurses under the direction of licensed physicians or dentists to eligible individuals residing in congregate care facilities (WAC § 388-15-620, 1992).

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Department of Social and Health Services (DSHS). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

MPC

Services are provided by personal care providers from a qualified home care agency if the care service plan does not exceed 85 hours per month. If services rendered exceed 85 hours per month, a consumer-selected individual provider contracted with the state must be hired. Individuals are prohibited from hiring immediate family members as individual providers (WAC §§ 388-15-820, 388-15-870, 1992).

Nursing Facility Care

Care is provided by registered nurses, licensed practical nurses, and other auxiliary staff employed by a state registered nursing facility (WAC § 388-88, 1992).

COPES

The provision of care for program services will vary by authorized service (Medicaid.gov, 2025). Participants may hire a relative other than their spouse to provide personal care services covered under COPES. The state will only pay fathers, mothers, sons, or daughters of participants if that individual has a gross income less than the medically needy income limit (WAC § 388-15-630, 1992). Mention of this income restriction is not present in the state legislation after 1995.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the 3 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

MPC

MPC services must be medically necessary as prescribed by a physician. To be eligible for MPC services, applicants must require physical assistance with at least 1 direct personal care task (WAC § 388-15-830, 1993). The number of authorized service hours are based on the level of assistance needed with each task using the following 4-point scale: none/independent, minimal, substantial, and total. Each level corresponds to a point value detailed in Table 4, which determines the total number of authorized service hours using the conversion chart in Table 5. Available sources do not specify whether "physical assistance" corresponds to minimal, substantial, or total on the dependency scale.

From 1996, MPC no longer considered all direct personal care tasks when determining eligibility for services. Instead, applicants must require physical assistance with at least 1 activity of daily living (ADL), but whether "physical assistance" corresponds to a specific level on the existing scale remained unspecified. Ability to perform other direct personal care tasks continued to inform the plan of care, and the existing scoring system continued to be used to calculate the amount and duration of services, but neither were included in eligibility determinations (WAC §§ 388-15-202(17), 388-15-830, 1996).

Nursing Facility Care

To be eligible for nursing facility care, an individual must meet a nursing facility level of care (NFLOC), meaning they require services provided by or under the direction of a registered nurse (RN) or licensed practical nurse (LPN) at least daily (WAC § 388-88-081, 1992; WAC § 388-97-235, 1997a).

From 2001, the individual must require at least 1 of the following to satisfy an NFLOC (WAC § 388-71-0435, 2001):

- Services provided by or under the supervision of an RN or LPN at least daily
- Minimal assistance with at least 3 ADLs
- Substantial assistance with at least 2 ADLs
- Supervision due to a cognitive impairment and require substantial assistance with at least 1 ADL

COPES

To be eligible for COPES, an individual must meet an NFLOC, meaning they require services provided by or under the direction of an RN or LPN at least daily, or be institutionalized, or not institutionalized but likely to become institutionalized in the next 30 days if not for COPES services. The legislation defines "likely to become institutionalized in the next 30 days" as someone who meets all the following criteria (WAC § 388-15-610, 1992; WAC § 388-15-610, 1993):

- Has medical problems or cognitive impairment and cannot maintain or coordinate their treatment plan
- Lives alone or has inadequate support and unattended needs throughout the day
- Has an unmet need for assistance with at least 2 ADLs

From 1996, an individual must have medical problems or a cognitive impairment and be unable to maintain or coordinate a treatment plan, be ineligible for MPC (or eligible but the amount, duration, or scope exceeds what MPC can provide), and require 1 of the following (WAC § 388-15-610, 1996):

- Services provided by or under the supervision of an RN or LPN at least daily
- Substantial assistance with at least 2 ADLs
- Minimal assistance with at least 3 ADLs
- Supervision due to a cognitive impairment and require substantial assistance with at least 1 ADL

Alternatively, individuals who reside in a nursing facility but need COPES to return to the community may be eligible.

From 2001, an individual must be community dwelling, ineligible for MPC (or eligible but the amount, duration, or scope exceeds what MPC can provide), and meet an NFLOC as described above under Nursing Facility Care's 2001 criteria (WAC § 388-71-0475, 2001).

Duration of benefit

Reassessments of eligibility differ vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for Washington's 3 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least annually (42 CFR § 435.916, 2025).

MPC

A physician must review the plan of care at least annually. Additionally, a registered nurse must visit the beneficiary every 90 days to review the plan of care, the individual's continued need for care, and to assess the quality of care received (WAC § 388-15-840, 1992). From 1996, beneficiaries must only be reassessed annually or more often if needed.

Nursing Facility Care

Residents of nursing facilities must be reassessed annually or more often if needed. Nursing facilities review the plan of care for each resident every 90 days (WAC § 388-81, 1992).

COPES

Participants must be reassessed annually to determine level of care (WAC § 388-71-0450, 2001).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for Washington's 3 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid (WAC § 388, 1992; WAC § 388, 2003; WAC § 388-106, 2025d).

MPC, Nursing Facility Care

There is no age requirement.

COPES

Individuals must be at least age 65, or aged 18-64 and disabled (Medicaid.gov, 2025).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC

MPC services must be medically necessary as prescribed by a physician. To be eligible for MPC services, applicants must require physical assistance with at least 1 direct personal care task (WAC § 388-15-830, 1993). The number of authorized service hours are based on the level of assistance needed with each task using the following 4-point scale: none/independent, minimal, substantial, and total. Each level corresponds to a point value detailed in Table 4, which determines the total number of authorized service hours using the conversion chart in Table 5. Available sources do not specify whether "physical assistance" corresponds to minimal, substantial, or total on the dependency scale (WAC § 388-15-203, 1993).

From 1996, MPC no longer considered all direct personal care tasks when determining eligibility for services (WAC § 388-15-830, 1996). Instead, applicants must require physical assistance with at least 1 activity of daily living (ADL), but whether "physical assistance" corresponds to a specific level on the existing scale remained unspecified. Ability to perform other direct personal care tasks continued to inform the plan of care, and the existing scoring system continued to be used to calculate the amount and duration of services, but neither were included in eligibility determinations. Levels of assistance needed for each ADL are defined in Table 6 (ambulation, bathing, body care, dressing, and eating) and Table 7 (personal hygiene, positioning, self-medication, toileting, and transferring).

Nursing Facility Care

To be eligible for nursing facility care, an individual must meet a nursing facility level of care (NFLOC), meaning they require services provided by or under the direction of a registered nurse (RN) or licensed practical nurse (LPN) at least daily (WAC § 388-88-081, 1992; WAC § 388-97-235, 1997a).

From 2001, the individual must require at least 1 of the following to satisfy an NFLOC (WAC § 388-71-0435, 2001):

- Services provided by or under the supervision of an RN or LPN at least daily
- Minimal, substantial, or total assistance with at least 3 ADLs
- Substantial or total assistance with at least 2 ADLs
- Supervision due to a cognitive impairment (disorientation, memory impairment, impaired judgement, or wandering), and require substantial or total assistance with at least 1 ADL

Levels of assistance needed for each ADL are defined in Table 6 (eating, toileting, ambulation, and transferring) and Table 7 (bathing, body care, positioning, self-medication, dressing, and personal hygiene).

COPES

To be eligible for COPES, an individual must meet an NFLOC, meaning they require services provided by or under the direction of an RN or LPN at least daily, or be institutionalized, or not institutionalized by likely to become institutionalized in the next 30 days if not for COPES services. The legislation defines "likely to become institutionalized in the next 30 days" as someone who meets all the following criteria (WAC § 388-15-610, 1992; WAC §§ 388-15-615, 388-83-200, 1993):

- Has medical problems or cognitive impairment and cannot maintain or coordinate their treatment plan
- Lives alone or has inadequate support and unattended needs throughout the day
- Has an unmet need for assistance with 2 or more ADLs

From 1996, an individual must have medical problems or cognitive impairment and be unable to maintain or coordinate a treatment plan, be ineligible for MPC (or eligible for MPC but the amount, duration, or scope exceeds what MPC can provide), and require 1 of the following (WAC § 388-15-610, 1996; WAC § 388-15-610, 1997a):

- Services provided by or under the supervision of an RN or LPN at least daily
- Minimal, substantial, or total assistance with 3 or more ADLs
- Substantial or total assistance with 2 or more ADLs
- Supervision due to a cognitive impairment and require substantial or total assistance with 1 ADL (from 1997, a qualifying cognitive impairment is defined as the individual requiring supervision due to disorientation, memory impairment, impaired judgement, or wandering)

Alternatively, individuals who reside in a nursing facility but need COPES to return to the community may be eligible.

From 2001, an individual must be community dwelling, ineligible for MPC (or eligible but the amount, duration, or scope exceeds what MPC can provide), and meet an NFLOC as described above under Nursing Facility Care's 2001 criteria (WAC § 388-71-0475, 2001).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC

MPC must be medically necessary as prescribed by a physician. To be eligible for MPC services, applicants must require physical assistance with at least 1 of the following direct personal care tasks: ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, self-medication, toileting, transfers, and travel to medical services (WAC § 388-15-830, 1993). Each task is evaluated using the following 4-point scale: none/independent, minimal, substantial, and total (WAC § 388-15-203, 1993). An applicant's ability to perform household tasks including essential shopping, meal preparation, laundry, housework, and wood supply area assessed to inform the plan of care but are not included in eligibility determinations. From 1995, essential shopping was included in eligibility determinations. However, in 1996, both essential shopping and travel to medical services were no longer considered. The number of authorized service hours are based on a conversion chart detailed in the *Definition of dependence* section of this policy period (chapter). Evaluators also document the applicant's preference for care provision and any current or potential contributions by formal or informal caregivers (WAC § 388-15-840, 1992).

From 1996, MPC only considered activities of daily living (ADLs) when determining eligibility. These include ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, self-medication, toileting, and transfer (WAC §§ 388-15-202(17), 388-15-830, 1996). Levels of assistance needed for each ADL are defined in Table 6 (ambulation, bathing, body care, dressing, and eating) and Table 7 (personal hygiene, positioning, self-medication, toileting, and transfer). Ability to perform other direct personal care tasks (i.e., travel to medical services, essential shopping, meal preparation, housework, laundry, wood supply) continued to inform the plan of care, and the existing scoring system continued to be used to calculate the amount and duration of services, but neither were included in eligibility determinations (WAC § 388-15-890, 1996).

Nursing Facility Care

To be eligible for nursing facility care, an individual must meet a nursing facility level of care (NFLOC), determined by a standardized assessment tool that evaluates an individual's ability to perform the following ADLs: ambulation, bathing, eating, positioning, self-medication, toileting, and transferring (WAC § 388-15-202, 1993). An individual is determined to require an NFLOC if they require treatment and services performed under the daily direction of a registered nurse (RN) or licensed practical nurse (LPN), however details for how this is determined are not documented in state legislation (WAC § 388-081, 1992; WAC § 388-97-235, 1997a).

From 2001, an NFLOC is determined by an individual's ability to perform the following ADLs: bathing, bed mobility and positioning, eating, toileting, transferring, and walking (WAC § 388-71-0435, 2001). Each task is evaluated using the following 4-point scale: none/independent, minimal, substantial, and total. Levels of assistance needed for each ADL are defined in Table 6 (ambulation, bathing, and eating) and Table 7 (positioning, toileting, and transferring). Applicants are also assessed on cognitive abilities, however criteria for determining whether an individual has a cognitive impairment that requires supervision due to disorientation, memory impairment, impaired judgement, or wandering are not explicitly detailed in state legislation.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed. See Box 2 for more information on the PASRR, and Box 3 for the MDS.

COPES

To be eligible for COPES, an individual must meet an NFLOC, determined by the same standardized assessment tool described above under Nursing Facility Care. The same 4-point scale is also used to determine COPES eligibility; however, COPES assesses slightly different ADLs: ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, prescribed medication, toileting, and transferring (WAC § 388-15-203, 1993). From 1997, dressing, body care, and personal hygiene were no longer considered when determining COPES eligibility (WAC § 388-15-610, 1997a). Levels of assistance needed for each ADL are defined in Table 6 (ambulation, bathing, body care, dressing, and eating) and Table 7 (personal hygiene, positioning, prescribed-medication, toileting, and transferring).

Evaluators

The details of the 3 largest programs are summarized below.

Nurses or case managers from the Department of Social and Health Services (DSHS) evaluate applicants for MPC, Nursing Facility Care, and COPES and conduct functional eligibility assessments to determine level of care (WAC § 388-15-203, 1992).

Benefit limitations

Can you mix LTC benefits?

All Washington Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for Washington's 3 largest programs.

Medicaid

As required by federal law, Washington enforces Estate Recovery. The acceptance of Medicaid in Washington creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance as follows (WAC §§ 388-527-2740, 388-527-2842, 2001):

- (1992-July 1, 1994) All Medicaid services received after the recipient reached age 65
- (July 1, 1994-June 30, 1995) Nursing facility services, home and community-based services - HCBS (e.g., COPES), and related hospital or prescription drug services received after the recipient reached age 55
- (From July 1, 1995) Nursing facility services, HCBS (e.g., COPES), related hospital or prescription drug services, and state plan LTC benefits including adult day health and MPC services received after the recipient reached age 55

Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (WAC § 388-527-2733, 2001). See Box 4 for a timeline of important changes to Washington's estate recovery rules.

MPC

There are no copayments or similar charges imposed upon participants for program services (Washington State Health Care Authority, 2021).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 1992, the PNA was $38.84 per month (WAC § 388-513-1380, 1993). See Table 8 for historical PNA amounts in Washington.

COPES

There are no copayments or similar charges imposed upon participants for program services if they received Supplemental Security Income (SSI) (WAC § 388-83-200, 1993).

Author's note: State legislation after 1993 does not explicitly state that SSI recipients are exempt from participating in user charges for COPES, but it also does not provide any evidence that the SSI exemption was removed.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2003-2013

Policy change in 2003

In 2003, Washington state implemented a new long-term care assessment tool called the Comprehensive Assessment Reporting Evaluation (CARE). CARE became the new assessment tool used in determining eligibility for Medicaid Personal Care (MPC), nursing facility care, and Community Options Program Entry System (COPES). Levels of assistance for activities of daily living (ADLs) were redefined, and program eligibility criteria was updated to reflect the implementation of CARE. While CARE was first implemented in 2003, it is possible that full implementation of the tool did not occur until at least 2005, as state legislation prior to 2005 includes information for both CARE and the standardized assessment tool detailed in the previous policy period (chapter) (WSR, 2003a; WSR, 2005).

Other policy changes during this period:

- (2003) Washington implemented a new state maximum community spouse resource allowance (CSRA) of $40,000. For individuals institutionalized on or after August 1, 2003, the community spouse can retain 50% of the couple's assets up to the federal maximum of $90,660. If 50% of the couple's assets is equal to or less than the new Washington state standard, the community spouse may retain up to the state maximum of $40,000. The state standard CSRA increases biennially with inflation on July 1 of every odd year. Prior to 2003, the community spouse was entitled to the federal maximum CSRA (WSR, 2004).
- (2003) Effective December 20, 2003, MPC updates functional eligibility criteria, creating additional eligibility pathway (WSR, 2003b). See the *Minimum Level of Dependence* and *Care Needs Assessment* sections of this policy period (chapter) for the updated criteria.
- (2005) The personal needs allowance (PNA) increases to $51.62 for all nursing facility residents. The PNA increased again to $53.68 in 2006, $55.45 in 2007, and $57.28 in 2008 where it remains (WSR, 2005; WSR, 2007; WAC § 388-513-1380, 2009).
- (2006) The Deficit Reduction Act of 2005 enacted 2 policy changes affecting financial eligibility criteria for Washington Medicaid:
  - The look back period for asset transfers increases from 36 months (60 months for a trust) to 60 months for all assets (WAC § 388-513-1363, 2008).
  - A home equity limit that makes individuals with home equity above $500,0000 ineligible for LTC. Prior to 2006, in determining an applicant's assets, the value of an individual's home was usually exempt. Homes occupied by a spouse or a disabled or minor child are exempt. From 2011, this figure increases annually with inflation (WSR 11-10-038, 2011a).
- (2007) MPC adds nursing services to the list of covered benefits (WAC § 388-106-0200, 2007).
- (2009) Individuals may qualify for COPES under eligibility track 3a (Medically needy aged, blind, or disabled) as of April 1, 2009 (DSHS p.16, 2009). Prior to 2009, COPES eligibility was limited to eligibility track 1a (Supplemental Security Income recipients) and 2a (Institutional rules for people receiving LTC) and only nursing facility residents could qualify for Medicaid under track 3a (DSHS p. 12, 2006).
- (2011) The Washington State Health Care Authority (HCA) replaces the Department of Social and Health Services (DSHS) as the single state agency for Medicaid administration. Some Medicaid programs continued to be overseen by DSHS (Medicaid.gov, 2011; Washington State Register, 2011b).

Overview

Long-term care (LTC) benefits in Washington are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Washington is administered at the state level by the Washington Department of Social and Health Services (DSHS) until July 2011, when responsibilities were transferred to the Washington State Health Care Authority (HCA) (Washington State Register, 2011b). Enrollment is voluntary. For consistency, we use DSHS throughout this policy period (chapter).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Washington are mostly provided through state plan benefit programs (Medicaid Personal Care - MPC, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Community Options Program Entry System - COPES).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. MPC provides home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COPES are also able

to receive a variety of LTC benefits if deemed medically eligible, such as home home health services. Those applying for COPES are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. MPC requires the individual to have a medical necessity for services, while Nursing Facility and COPES beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025d)

Washington Law for Medicaid

- Washington Administrative Code (WAC), Chapter 388 (1992, 1993, 1996, 1997a, 1997b, 2001, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2014b, 2016, 2025c, 2025d)
- Washington Administrative Code (WAC), Chapter 182 (2014a, 2024, 2025a, 2025b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Washington Medicaid spending on beneficiaries in fiscal year 2003 was 51.66%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Washington Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Washington.

Eligibility for Medicaid in Washington for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients

- ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2003, the monthly federal benefit amount was $552 for an individual and $829 for a couple (SSA, 2025a). See Table 2 for historical monthly benefit amounts.
- ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (WAC § 388-95, 2003). This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999). See Box 1 for a list of included and excluded resources.
  - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (WAC § 388-92-043, 1992).[10]
  - ▪ Home equity limit: From 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. From 2011, this figure increase annually with inflation (WSR, 2011a).[11] See Table 9 for historical home equity limits.
- ◇ Citizenship/immigration requirements (SSA, 1998): The applicant must be a Washington resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2025b) for additional information.[4]
- ◇ Other requirements
  - ▪ The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2003, this was $1,656 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or participating in COPES and has a spouse residing in the community.[12] See Table 3 for historical monthly spousal disregards (WAC § 388-513-1360, 2003).
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or participating in COPES and has a spouse residing in the community.[13] See Table 3 for historical monthly spousal disregards.
    - ▪ Asset transfer & home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - ▪ The applicant must be receiving or in need of LTC services through nursing facility care or COPES.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, institutionalized individuals must "spend down" their excess income over a 3-month or 6-month period to be equal or less than the medically needy income limit. In 2003, this was $571 per month for an individual and $592 per month for a couple (WAC § 388-478-0070, 2003). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[12] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple, plus $50 for each additional family member in the household (WAC § 388-478-0070, 2003).[13]
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - ▪ The applicant must be at least age 65, blind, or disabled.[4]
    - ▪ Individuals participating in COPES may not qualify for Medicaid through this eligibility track until 2009 (DSHS p.16, 2009).

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become

eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Medicaid Personal Care (MPC), Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program Entry System (COPES)

Beyond meeting minimum level of dependence requirements, individuals must be at least age 65 or between age 18-64 and disabled (Medicaid.gov, 2025).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult day health (until 2011)
- Adult foster care
- Chore services
- Home Health[8]
- Private duty nursing
- Program of All-inclusive Care for the Elderly (PACE)
- Medically Needy Residential Program (until 2012)
- New Freedom Program —from 2005
- Medically Needy In-home Program (2007-2012)

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC

MPC provides the following home care services (WAC § 388-15-840, 2003; WAC § 388-106-0200, 2007):

- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Nursing services (from 2007): Skilled treatment that requires authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse (e.g., medication administration, wound care/debridement) in emergency situations only

Nursing Facility Care

Nursing facility care does not provide home care.

COPES

COPES provides the following home care services (WAC § 388-71-0415, 2005; WAC § 388-106-300, 2007):

- Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care
- Personal care services: As described above under MPC Services
- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, only covered if provided by a registered nurse or licensed practical nurse and services are beyond the amount, duration or scope of the state plan home health benefit

COPES will also cover skilled nursing services for individuals residing in a residential care facility.

Community care

Community care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC, Nursing Facility Care

These programs do not provide community care.

COPES

COPES provides adult day health care (ADHC), which provides center-based daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAC § 388-15-620, 1992; WAC § 388-15-620, 1996; Medicaid.gov, 2025).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 3 largest programs are summarized below.

MPC, COPES

These programs do not provide residential care.

Nursing Facility Care

Washington Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; WAC § 388-88, 1992; WAC § 388-97, 2003). Services may include the following:

- Physician services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Community care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Washington's largest home and community-based services (HCBS) program.

Washington Medicaid provides additional state plan benefits related to LTC (WAC § 388-15, 2003):

- Durable medical equipment: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services[8]
- Hospice: Care is available to residents of nursing facilities if that nursing facility is serviced by a hospice provider
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COPES

The COPES program provides the following services in addition to those offered under the state plan, unless otherwise noted (WAC § 388-71-0415, 2003; Medicaid.gov, 2025):

- Home delivered meals: Planning, preparation and delivery of 1 meal per day to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance
- Home/Environmental Modifications: Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's health and safety
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Specialized Medical Equipment and Supplies: Items in addition to those provided by the state plan durable medical equipment benefit that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids
- Client training: Service provided to assist participants in achieving specific therapeutic goals including adjusting serious impairments, managing personal care needs, or developing skills necessary to deal with care providers
- Transportation: Assistance and escort of participant to non-medical appointments and community outings
- Nurse delegation (from 2005): If the individual is receiving personal care services from a registered nurse or certified nursing assistant who has completed nurse delegation core training and their medical condition is considered stable and predictable by the delegating nurse

Though COPES primarily provides services to community-dwelling individuals, the program provides specialized durable medical equipment and nondurable medical equipment and supplies, participant training, transportation, and skilled nursing to individuals living in a residential setting (WAC § 388-71-0415, 2003).

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Department of Social and Health Services (DSHS). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

MPC

Services are provided by personal care providers from a qualified personal care agency or by a consumer-selected individual provider contracted with the state. Individuals are prohibited from hiring spouses as individual providers (WAC § 388-71-0540, 2003).

Nursing Facility Care

Care is provided by registered nurses (RNs), licensed practical nurses (LPNs), and other auxiliary staff employed by a state registered nursing facility (WAC § 388-88, 1992).

COPES

The provision of care for program services will vary by authorized service (Medicaid.gov, 2025). Participants may hire a relative other than their spouse to provide personal care services covered under COPES (WAC § 388-15-630, 1997a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the 3 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

MPC

MPC services must be medically necessary as prescribed by a physician. To be eligible for MPC services, applicants must have an unmet need with at least 1 activity of daily living (ADL) (WAC § 388-71-0440, 2003).

From March 2003, applicants must have an unmet or partially met need with at least 1 ADL as detailed in section (1) of Table 10 (WSR, 2003a).

From December 2003, applicants must meet the criteria for at least 1 of 2 alternative eligibility pathways detailed in Table 10 (WSR, 2003b).

Nursing Facility Care, COPES

To be eligible for nursing facility care and COPES, an individual must meet a nursing facility level of care (NFLOC). The individual must require at least 1 of the following to satisfy an NFLOC (WSR, 2003a; WSR, 2005; WAC § 388-106-0355, 2007):

- Services provided by or under the supervision of an RN or LPN at least daily
- Unmet or partially met need with at least 3 ADLs as detailed in Table 11
- Unmet or partially met need with at least 2 ADLs as detailed in Table 11
- Supervision due to a cognitive impairment and require assistance with at least 1 ADL as detailed in Table 11

See Table 12 for definitions of levels of assistance.

To be eligible for COPES, an individual must also be community dwelling and ineligible for MPC (or eligible for MPC but the amount, duration, or scope of needs is beyond what MPC can provide), and require at least 1 program service per month (WSR, 2003b; DSHS, 2022). Additionally, some services may require prior authorization.

Duration of benefit

Reassessments of eligibility differ vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for Washington's 3 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least annually (42 CFR § 435.916, 2025).

MPC, COPES
Participants must be reassessed annually or more often if needed (WAC §§ 388-106-0220, 388-106-0320, 2007).

Nursing Facility Care
Residents of nursing facilities must be reassessed annually or more often if needed. Nursing facilities review the plan of care for each resident every 90 days (WAC § 388-81, 1992).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for Washington's 3 largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid (WAC § 388, 1992; WAC § 388, 2003; WAC § 388-106, 2025d).

MPC, Nursing Facility Care
There is no age requirement.

COPES
Individuals must be at least age 65, or aged 18-64 and disabled (Medicaid.gov, 2025).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. In Washington, MPC, Nursing Facility Care, and COPES use the Comprehensive Assessment Reporting Evaluation (CARE). Standard levels of assistance for each activity of daily living (ADL) assessed in CARE are determined using 2 categories of assistance: self-performance and support provided. The scale for self-performance includes independent, supervision, limited assistance, extensive assistance, and total assistance. The scale for support provided includes none, setup help only, 1-person physical assist, and 2-person physical assist (WSR, 2005). See Table 12 for definitions of levels of assistance. The details of the 3 largest programs are summarized below.

MPC
MPC services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. To be eligible for MPC services, applicants must have an unmet need with at least 1 activity of daily living (ADL) (WAC § 388-71-0440, 2003).

From March 2003, applicants must have an unmet or partially met need with at least 1 ADL as detailed in section (1) of Table 10 (WSR, 2003a).

From December 2003, applicants must have 1 of the following (WSR, 2003b; WSR, 2005):

- Unmet or partially met need with at least 3 ADLs as defined in section (1) of Table 10
- Unmet or partially met need with at least 1 ADL as defined in section (2) of Table 10

The level of assistance an applicant requires with an ADL is assigned a point value, which in conjunction with other factors is used to place applicants into a classification group and determine the maximum number of MPC services hours an individual may receive each month. See WAC §§ 388-106-0080 (2007) for more information about the classification system.

Nursing Facility Care, COPES
To be eligible for nursing facility care and COPES, an individual must meet a nursing facility level of care (NFLOC). The individual must require at least 1 of the following to satisfy an NFLOC (WAC § 388-72A-0055, 2004; WSR, 2005):

- Services provided by or under the supervision of an RN or LPN at least daily
- Unmet or partially met need with at least 3 ADLs as defined in Table 11
- Unmet or partially met need with at least 2 ADLs as defined in Table 11

- Supervision due to a cognitive impairment (disorientation, memory impairment, impaired judgement, or wandering) and an unmet or partially met need with at least 1 ADL as defined in Table 11

To be eligible for COPES, an individual must also be community dwelling and ineligible for MPC (or eligible for MPC but the amount, duration, or scope of needs is beyond what MPC can provide), and require at least 1 program service per month (WSR, 2003b; DSHS, 2022). Additionally, some services may require prior authorization.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. In Washington, MPC, Nursing Facility Care, and COPES use the Comprehensive Assessment Reporting Evaluation (CARE). The assessment evaluates physical health, functional abilities, and cognitive abilities of all applicants, however, items assessed to determine eligibility differ by program. Standard levels of assistance for each activity of daily living (ADL) assessed in CARE are determined using 2 categories of assistance: self-performance and support provided during the 7 days prior to the evaluation. See Table 12 for definitions of levels of assistance. Minimum eligibility thresholds for each program are detailed in the *Benefit Eligibility* section. Applicants receive scores based on level of assistance needed with each ADL and these scores are one component of a standardized classification system that is used to determine the amount of authorized in-home services for each applicable program (WAC §§ 388-106-0080, 2007). The details of the 3 largest programs are summarized below.

MPC

MPC services must be medically necessary as prescribed by a physician. To be eligible for MPC, applicants must have an unmet or partially met need with ADLs including ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, self-medication, toileting, and transfers.

From March 2003, applicants must require assistance with at least 1 ADL as detailed in section (1) of Table 10 (WSR, 2003a). From December 2003, applicants must meet the criteria for at least 1 of 2 ADL-dependent eligibility pathways detailed in Table 10 (WSR, 2003b).

The level of assistance an applicant requires with an ADL is assigned a point value, which in conjunction with other factors is used to place applicants into a classification group and determine the maximum number of MPC services hours an individual may receive each month. See WAC §§ 388-106-0080 (2007) for more information about the classification system. Ability to complete instrumental ADLs (IADLs) like shopping and meal preparation may be assessed to inform the individual's care plan but are not required for eligibility (WAC § 388-71-0203, 2003; WAC § 388-106-0210, 2007).

From 2004, ambulation was separated into 3 tasks: (1) locomotion in room and immediate living environment, (2) locomotion outside of immediate living environment, and (3) walking in room, hallway, and rest of immediate environment. Additionally, self-medication was renamed "medication management" and bed mobility was added to the list of ADLs assessed (WAC § 388-71-0203, 2003; WAC § 388-72A, 2004).

Nursing Facility Care, COPES

To be eligible for nursing facility care or COPES, an individual must meet a nursing facility level of care (NFLOC). The individual's ability to perform ADLs including ambulation, bathing, eating, positioning, self-medication, toileting, and transferring must meet criteria for at least 1 of 3 alternative ADL-dependent eligibility pathways detailed in Table 11 to satisfy an NFLOC (WSR, 2005). Pathways 1 and 2 only require assistance with ADLs, while pathway 3 requires a cognitive assessment. See Box 5 for information on how cognition is assessed for this pathway.

From 2004, ambulation was separated into 3 tasks and self-medication was renamed "medication management," as described above under MPC. Additionally, positioning is renamed "bed mobility and turning/repositioning" (WAC 388-72A, 2004).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed. See Box 2 for more information on the PASRR, and Box 3 for the MDS.

Evaluators

The details of the 3 largest programs are summarized below.

Nurses or case managers from the Department of Social and Health Services (DSHS) evaluate applicants for MPC, Nursing Facility

Care, and COPES and conduct functional eligibility assessments to determine level of care (WAC § 388-15-203, 1992).

Benefit limitations

Can you mix LTC benefits?

All Washington Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for Washington's 3 largest programs.

Medicaid

As required by federal law, Washington enforces Estate Recovery. The acceptance of Medicaid in Washington creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance as follows (WAC § 388-527-2742, 2003; WAC § 182-527-2742, 2025b):

- (Until May 31, 2004) Nursing facility services, home-and community-based services (HCBS), adult day health, MPC, private duty nursing, and related prescription drug services provided after the individual turned 55
- (June 1, 2004-December 31, 2013) Any Medicaid services rendered after the individual turned 55

Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (WAC § 388-527-2737, 2003). See Box 4 for a timeline of important changes to Washington's estate recovery rules.

MPC, COPES

There are no copayments or similar charges imposed upon participants for program services (WAC § 388-515-1505, 2007).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2003, the PNA was $41.62 per month (WAC § 388-513-1380, 2003). This amount increased to $51.62 per month in 2005, $53.68 in 2006, $55.45 in 2007, and $57.28 in 2008, where it remains (WSR, 2007). See Table 8 for historical PNA amounts in Washington.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2014-2025

Policy change in 2014

In 2014, Washington adopted Medicaid expansion following passage of the Affordable Care Act (ACA), creating a new eligibility track covering adults age 19-64 with incomes up to 138% of the federal poverty level (FPL), referred to here as eligibility track 2c (ACA expansion adults). Adoption of the ACA also required states to extend spousal impoverishment rules to community spouses of individuals in the Community Options Program Entry System (COPES) home-and community-based services (HCBS) program under eligibility track 2a (Institutional rules for people receiving LTC), however it is possible that Washington decided to extend this policy earlier. Finally, adoption of the ACA allowed for the creation of Community First Choice (CFC), a program that provides expanded HCBS through the state plan to individuals that meet a nursing facility level of care. CFC was officially implemented in July 2015.

Other policy changes during this period:

- (2014) Washington renamed the state Medicaid program to "Washington Apple Health" (Medicaid.gov, 2014). For consistency, we refer to the state's Medicaid program as Washington Medicaid.
- (2015) Following implementation of CFC, Washington transferred individuals receiving Medicaid Personal Care (MPC) or personal care services through COPES who meet an NFLOC to CFC to receive personal care services (DSHS, 2015).
- (2015) COPES added Wellness Education as a covered service and removed personal care, nurse delegation, personal emergency response system (PERS), and community transition services from the list of benefits (DSHS, 2015; WSR 15-11-049, 2015). From July 1, 2015, the removed services were offered under CFC.
- (2015) MPC eligibility rules are updated. Following implementation of CFC, individuals applying to MPC must not meet an NFLOC (WSR, 2015).
- (2017) The COPES program removed home health aide services as a covered service (DSHS, 2016; DSHS, 2017).
- (2019) COPES added Community Choice Guide and Community Support: Goods and Services to the list of covered services (DSHS, 2019).
- (2019) Established by the Long-Term Services and Supports Trust Act passed in 2019, Washington implemented the WA Cares Fund, a universal public LTC insurance program. This is the first program of its kind in the United States. See Box 6 for more information on the program (WA. Leg., 2019; Washington.gov, 2025).
- (2022) Washington adjusted the home equity limit standard to the federal maximum, which is $955,000 in 2022. Prior to 2022, Washington used the federal minimum standard to set the home equity limit (Medicaid.gov, 2022).

Overview

Long-term care (LTC) benefits in Washington are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Washington is administered at the state level by the Washington State Health Care Authority (HCA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Washington are mostly provided through state plan benefit programs (Medicaid Personal Care - MPC, Nursing Facility Care, Community First Choice - CFC) or through federally approved home-and community-based services (HCBS) LTC programs (COPES). In 2019, Washington implemented WA Cares Fund, a statewide long-term care insurance program detailed in Box 6. This document provides policy information on Washington's Medicaid LTC benefits, and the WA Cares Fund will be detailed in a separate policy document.

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. MPC Services and Home Health provide home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by COPES and CFC are also able to receive a variety of LTC benefits if deemed medically eligible, such as Personal Emergency Response System - PERS. Those applying for COPES are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. MPC requires the individual to have a medical necessity for services, while Nursing Facility, COPES, and CFC beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025d)

Washington Law for Medicaid

- Washington Administrative Code (WAC), Chapter 388 (1992, 1993, 1996, 1997a, 1997b, 2001, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2014b, 2016, 2025c, 2025d)
- Washington Administrative Code (WAC), Chapter 182 (2014a, 2024, 2025a, 2025b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Washington Medicaid spending on beneficiaries in fiscal year 2014 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.[14]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Washington Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Washington.

Eligibility for Medicaid in Washington for people needing LTC services is primarily attained by satisfying at least 1 of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2014, the monthly federal benefit amount was $721 for an individual and $1,082 for a couple (SSA, 2025a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (HCA, 2014). This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999). See Box 1 for a list of included and excluded resources.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (WAC § 182-513-1363, 2014).[15]

        - Home equity limit: The equity interest in an individual's home may not exceed $543,000, or else they will be ineligible for LTC services. This figure increases annually with inflation (CMR § 182-513-1350, 2014).[11] From 2022, home equity limits are subject to the federal maximum amount, and continue to increase annually with inflation. See Table 9 for historical home equity limits.
    - Citizenship/immigration requirements (SSA, 1998): The applicant must be a Washington resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2025b) for additional information.[4]
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
    - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (WAC § 182-515, 2014). In 2014, this was $2,163 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional income disregards exist when a person is institutionalized or participating in COPES and has a spouse residing in the community.[16] See Table 2 for historical income limits.
    - Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or participating in COPES and has a spouse residing in the community (HCA, 2023).[17] See Table 3 for historical monthly spousal disregards.
        - Asset transfer & home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving or in need of LTC services through nursing facility care or COPES.
- 2c. Affordable Care Act (ACA) expansion adults
    - Income requirements: Monthly income may not exceed 138% of the Federal Poverty Level (FPL). In 2014, this was $1,342 for an individual and $1,809 for a household of two. See Table 2 for historical income limits.
    - Asset requirements: There is no asset test for this population (KFF, 2018).
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - Income requirements: In order to be eligible under the medically needy track, institutionalized individuals must "spend down" their excess income over a 3-month or 6-month period to be equal or less than the medically needy income limit. In 2014, this was $721 per month for both individuals and couples (HCA, 2014). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized or participating in HCBS and has a spouse residing in the community.[16] See Table 3 for historical monthly spousal disregards.
    - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple, plus $50 for each additional family member in the household (WAC § 182-519-0050, 2024).[17]
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks
There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid (Medicaid) has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Medicaid Personal Care (MPC), Nursing Facility Care, Community First Choice (CFC)

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Options Program Entry System (COPES)
Beyond meeting minimum level of dependence requirements, individuals must be at least age 65 and not institutionalized, or between age 18-64 with a disability (Medicaid.gov, 2025).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult foster care
- Chore services
- Home Health[8]
- Private duty nursing
- Program of All-inclusive Care for the Elderly (PACE)
- New Freedom Program
- Residential Supports Program
- Adult day services
- Medicaid Alternative Care (caregiver support program)
- Tailored Supports for Older Adults (TSOA) —from 2017
- Roads to Community Living —from 2021

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

MPC
MPC provides the following home care services (WAC § 388-106-0200, 2014b; WAC § 388-106-0200, 2025d):

- Personal care services, which include:
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Nursing services: Includes assessment and reassessment, instruction to the beneficiary and their provider, care coordination, and skilled treatment in the event of an emergency only

Nursing Facility Care
Nursing facility care does not provide home care.

COPES
COPES provides the following home care services (WSR 15-11-049, 2015; DSHS, 2016; WAC § 388-106-0300, 2025d):

- Personal care services as described above in MPC (until 2015)
- Personal care services in a residential setting (until 2015)
- Home health aide services (until 2017): Including assistance with ADLs like ambulation, exercise, self-administered medication and hands-on personal care above the scope of state plan home health services [18]
- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, only covered if provided by a registered nurse or licensed practical nurse and services are beyond the amount, duration or scope of the state plan home health benefit (defined in WAC § 182-551-2100)
- Nursing services: As described above in MPC —based on individual need from CARE assessment if the services are not already being provided by another resource

CFC
From July 2015, CFC provides the following home care services (WSR 15-11-049, 2015; WAC § 388-106-0270, 2025d):

- Personal care services: As described above under MPC

- Nursing services: As described above under MPC, so long as the individual is not already receiving nursing services from another source

Community care

Community care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

MPC, Nursing Facility Care, CFC

These programs do not provide community care.

COPES

COPES provides adult day health care (ADHC), which provides center-based daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (WAC § 388-15-620, 1992; WAC § 388-15-620, 1996; Medicaid.gov, 2025).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

MPC, COPES, CFC

These programs do not provide residential care.

Nursing Facility Care

Washington Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; WAC § 388-97, 2025c). Services may include the following:

- Physician services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Community care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Washington's largest home and community-based services (HCBS) programs.

Washington Medicaid provides additional state plan benefits related to LTC (WAC §§ 182-543 - 182-556, 2025):

- Durable medical equipment: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services[8]
- Hospice: Care is available to residents of nursing facilities if that nursing facility is serviced by a hospice provider
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

COPES

COPES provides the following services in addition to those offered under the state plan, unless otherwise noted (DSHS, 2019; WAC § 388-106-0300, 2025d):

- Home-delivered meals: Planning, preparation and delivery of 1 meal per day to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance
- Home modification: Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's health and safety
- Personal Emergency Response System (PERS) (until 2015): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Specialized medical equipment and supplies (WAC § 182-543-1000, 2025b)
- Nurse delegation (until 2015): If the beneficiary is receiving personal care and their medical condition is considered stable and predictable
- Client support training & wellness education (from 2015): As determined by the CARE assessment, must meet a therapeutic goal
- Transportation: Transportation to community services and resources needed to meet a therapeutic goal

- Community choice guide (from 2019): Services to help individuals establish or stabilize their living arrangement at home if they have frequent institutional contacts, frequent turnover of caregivers, or are in jeopardy of eviction or loss of their current community
- Community supports —goods and services (from 2019): Non-recurring assistance with the logistics and expenses associated with transitioning out of a nursing facility or other congregate facility into the community

CFC

From 2015, CFC provides the following services that may be available in addition to the other state plan benefits listed above (WSR 15-11-049, 2015; WAC § 388-106-0270, 2025d):

- PERS: As defined under COPES
- Skills acquisition training: training that allows you to acquire, maintain, and enhance skills necessary to accomplish ADLs, IADLs, or health related tasks (specific tasks related to the needs of an individual that under state law licensed health professionals can delegate or assign to a qualified health care practitioner) more independently
- Assistive technology/ equipment: Includes PERS add-ons like fall-detection, GPS, medication reminders, adaptive utensils for eating, communication applications, visual alert systems, voice activated systems, switches and eye gazes, timers or electronic devices that monitor or sense movement and react in a prescribed manner such as turning on or off an appliance, repair or replacing items, and training participants/caregivers on the maintenance of equipment purchased
- Community transition services (called "Community Supports: Goods and Services" under COPES): As defined under COPES
- Nurse delegation: As defined under COPES
- Respite (called "Relief care" in Washington): Personal care services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Caregiver management training: Provides guidance to caregivers on how to select, manage, and dismiss a personal care provider

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Washington State Health Care Authority (HCA). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

MPC

Services are provided by personal care providers from a qualified personal care agency or by a consumer-selected individual provider contracted with the state. Individuals are prohibited from hiring spouses as individual providers (WAC § 388-71-0540, 2003).

Nursing Facility Care

Care is provided by registered nurses (RNs), licensed practical nurses (LPNs), and other auxiliary staff employed by a state registered nursing facility (WAC § 388-88, 1992).

COPES, CFC

The provision of care for program services will vary by authorized service (Medicaid.gov, 2025). Participants may hire a relative other than their spouse to provide personal care services covered under COPES (WAC § 388-15-630, 1997a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

MPC

MPC services must be medically necessary as prescribed by a physician. To be eligible for MPC services, applicants must meet the criteria for 1 of 2 alternative eligibility pathways detailed in Table 10 (WAC § 388-106-0210, 2014).

Nursing Facility Care, COPES, CFC

To be eligible for nursing facility care, COPES, and CFC, an individual must meet a nursing facility level of care (NFLOC). The individual must require at least 1 of the following to satisfy an NFLOC (WAC §§ 388-106-0310, 388-106-0355 2025d):

- Services provided by or under the supervision of a registered nurse or licensed practical nurse at least daily
- Unmet or partially met need with at least 3 ADLs as defined in Table 11
- Unmet or partially met need with at least 2 ADLs as defined in Table 11
- Supervision due to a cognitive impairment and require assistance with at least 1 ADL as defined in Table 11

See Table 12 for definitions of levels of assistance.

To be eligible for COPES and CFC, applicants must also be community dwelling and require at least 1 program service per month (e.g., wellness education, home delivered meals, adult day care/adult day health, skilled nursing, or specialized medical equipment) (DSHS, 2022). Additionally, some services may require prior authorization.

Duration of benefit

Reassessments of eligibility differ vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for Washington's 4 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least annually (42 CFR § 435.916, 2025).

MPC, COPES, CFC

Participants must be reassessed annually or more often if needed (WAC §§ 388-106-0220, 388-106-0283, 388-106-0320, 2025d).

Nursing Facility Care

Residents of nursing facilities must be reassessed annually or more often if needed. Nursing facilities review the plan of care for each resident every 90 days (WAC § 388-81, 1992).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for Washington's 4 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid (WAC § 388, 1992; WAC § 388, 2003; WAC § 388-106, 2025d).

MPC, Nursing Facility Care, CFC

There is no age requirement.

COPES

Individuals must be at least age 65, or aged 18-64 and disabled (Medicaid.gov, 2025).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. In Washington, MPC, Nursing Facility Care, COPES, and CFC use the Comprehensive Assessment Reporting Evaluation (CARE). Standard levels of assistance for each activity of daily living (ADL) assessed in CARE are determined using 2 categories of assistance: self-performance and support provided. The scale for self-performance includes independent, supervision, limited assistance, extensive assistance, and total assistance. The scale for support provided includes none, setup help only, 1-person physical assist, and 2-person physical assist (WSR, 2005). See Table 12 for definitions of levels of assistance. The details of the 4 largest programs are summarized below.

MPC

MPC services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. To be eligible for MPC services, applicants must have 1 of the following (WAC § 388-106-0210, 2025d):

- Unmet or partially met need with at least 3 ADLs as defined in Table 10
- Unmet or partially met need with at least 1 ADL as defined in Table 10

The level of assistance an applicant requires with an ADL is assigned a point value, which in conjunction with other factors is used to place applicants into a classification group and determine the maximum number of MPC services hours an individual may receive each month. See WAC § 388-106-0135 (2014) for more information about the classification system.

From 2016, the Washington legislation explicitly states that applicants to MPC must not meet a nursing facility level of care (NFLOC) (WAC § 388-106-0210, 2016).

Nursing Facility Care, COPES, CFC

To be eligible for nursing facility care, COPES, and CFC, an individual must meet an NFLOC. The individual must require at least 1 of the following to satisfy an NFLOC (WAC § 388-106-0355, 2014):

- Services provided by or under the supervision of a registered nurse or licensed practical nurse at least daily
- Unmet or partially met need with at least 3 ADLs as defined in Table 11
- Unmet or partially met need with at least 2 ADLs as defined in Table 11
- Supervision due to a coginitive impairment (disorientation, memory impairment, impaired judgement, or wandering) and an unmet or partially met need with at least 1 ADL as defined in Table 11

Additionally, applicants to COPES and CFC must be able to safely reside in the community and must require at least 1 program service per month (DSHS, 2022).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. In Washington, MPC, Nursing Facility Care, COPES, and CFC use the Comprehensive Assessment Reporting Evaluation (CARE). The assessment evaluates physical health, functional abilities, and cognitive abilities of all applicants, however, items assessed to determine eligibility differ by program. Standard levels of assistance for each activity of daily living (ADL) assessed in CARE are determined using 2 categories of assistance: self-performance and support provided during the 7 days prior to the evaluation. See Table 12 for definitions of levels of assistance. Minimum eligibility thresholds for each program are detailed in the *Benefit Eligibility* section. Applicants receive scores based on level of assistance needed with each ADL and these scores are one component of a standardized classification system that is used to determine the amount of authorized in-home services for each applicable program (WAC § 388-106-0130, 2014). The details of the 4 largest programs are summarized below.

MPC

MPC services must be medically necessary as prescribed by a physician. To be eligible for MPC, individuals must have an unmet or partially met need with ADLs including bathing, body care, dressing, eating, medication management, personal hygiene, walking in room, locomotion in room, or locomotion outside immediate living environment, toileting, and transfer, as detailed in Table 10 (WAC § 388-106-0210, 2025d). The level of assistance an applicant requires with an ADL is assigned a point value, which in conjunction with other factors is used to place applicants into a classification group and determine the maximum number of MPC services hours an individual may receive each month. See WAC § 388-106-0130 (2014) for more information about the classification system. Ability to complete instrumental ADLs (IADLs) like shopping and meal preparation may be assessed to inform the individual's care plan but are not required for eligibility (WAC § 388-106-0130, 2025d).

From 2016, the Washington legislation explicitly states that applicants to MPC must not meet a nursing facility level of care (NFLOC) (WAC § 388-106-0210, 2016).

Nursing Facility Care, COPES, CFC

To be eligible for nursing facility care, COPES, or CFC an individual must meet an NFLOC. The individual's ability to perform ADLs including bathing, eating, bed mobility and turning/repositioning, medication management, walking in room, locomotion in room, or locomotion outside immediate living environment, toileting, and transferring must meet criteria for at least 1 of 3 alternative ADL-dependent eligibility pathways detailed in Table 11 to satisfy an NFLOC (WAC § 388-106-0355, 2025d). Pathways 1 and 2 only require assistance with ADLs, while pathway 3 requires a cognitive assessment. See Box 5 for information on how cognition is assessed for this pathway.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate

whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed. See Box 2 for more information on the PASRR, and Box 3 for the MDS.

Evaluators

The details of the 4 largest programs are summarized below.

Nurses or case managers from the Department of Social and Health Services (DSHS) evaluate applicants for MPC, Nursing Facility Care, COPES, and CFC and conduct functional eligibility assessments to determine level of care (WAC § 388-106-0060, 2025d).

Benefit limitations

Can you mix LTC benefits?

All Washington Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for Washington's 4 largest programs.

Medicaid

As required by federal law, Washington enforces Estate Recovery. The acceptance of Medicaid in Washington creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for long-term care services including nursing facility care, home-and community-based services (HCBS) including COPES and CFC, MPC, and private duty nursing, or related prescription drug services after the individual turned 55 (WAC § 182-527-2742, 2025b). Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (WAC § 388-527-2737, 2003). See Box 4 for a timeline of important changes to Washington's estate recovery rules.

MPC, COPES, CFC

There are no copayments or similar charges imposed upon participants for program services (Medicaid.gov, 2025).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2014 the PNA was $57.28 (HCA, 2014a). See Table 8 for historical PNA amounts in Washington.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Washington Federal Medical Assistance Percentage (FMAP) for Medicaid (1992–2025)

Fiscal Year	FMAP
1992	54.98%
1993	55.02
1994	54.24
1995	51.97
1996	50.19
1997	50.52
1998	52.15
1999	52.50
2000	51.83
2001	50.70
2002	50.37
2003	51.66
2004	52.21
2005	50.00
2006	50.00
2007	50.12
2008	51.52
2009	61.58
2010	62.94
2011	57.85
2012	50.00
2013	50.00
2014	50.00
2015	50.03
2016	50.00
2017	50.00
2018	50.00
2019	50.00
2020	54.65
2021	56.20
2022	56.20
2023	54.98
2024	50.38
2025	50.00

Source: Congress.gov (2020), U.S. DHHS (2025)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period.

Table 2: Washington Medicaid Income Limits (1992–2025)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	138% FPL (Individual)	138% FPL (Couple)	Medically Needy (Individual)	Medically Needy (Couple)
1992	$422	$633	$1,266			$458	$575
1993	434	652	1,302			467	592
1994	446	669	1,338			467	592
1995	458	687	1,374			467	592
1996	470	705	1,410			496	592
1997	484	726	1,452			512	592
1998	494	741	1,482			521	592
1999	500	751	1,500			527	592
2000	513	769	1,539			539	592
2001	531	796	1,593			556	592
2002	545	817	1,635			571	592
2003	552	829	1,656			571	592
2004	564	846	1,692			571	592
2005	579	869	1,737			579	592
2006	603	904	1,809			603	603
2007	623	934	1,869			623	623
2008	637	956	1,911			637	637
2009	674	1,011	2,022			674	674
2010	674	1,011	2,022			674	674
2011	674	1,011	2,022			674	674
2012	698	1,048	2,094			698	698
2013	710	1,066	2,130			710	710
2014	721	1,082	2,163	$1,342	$1,809	721	721
2015	733	1,100	2,199	1,354	1,832	733	733
2016	733	1,100	2,199	1,367	1,843	733	733
2017	735	1,103	2,205	1,387	1,868	735	735
2018	750	1,125	2,250	1,397	1,893	750	750
2019	771	1,157	2,313	1,437	1,945	771	771
2020	783	1,175	2,349	1,468	1,983	783	783
2021	794	1,191	2,382	1,482	2,004	794	794
2022	841	1,261	2,523	1,564	2,106	841	841
2023	914	1,371	2,742	1,677	2,268	914	914
2024	943	1,415	2,829	1,732	2,352	943	943
2025	967	1,450	2,901	1,800	2,432	967	967

Source: CRS (2002), WAC § 388-478-0070 (2007), CRS (2011), Washington Health Care Authority (2011), SSA (2024a), SSA (2024b), CMS (2025b)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2014, corresponding to Washington's implementation of this track. Income of individuals who qualify for Medicaid through the 300% SSI track is evaluated independently from the applicant's spouse or other dependents. From 2006, medically needy income limits are the same regardless of the applicant's marital status. See WAC (2007) for more information.

Box 1: Supplemental Security Income (SSI) Resource Requirements

Individuals applying for Medicaid through eligibility track 1a (Supplemental Security Income - SSI recipients) must meet strict income and resource requirements. Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989, and includes the following countable resources: cash, bank accounts, stocks, mutual funds, U.S. savings bonds, land, life insurance, personal property, vehicles, anything an individual owns that could be changed to cash and used for food or shelter, and deemed resources. Deemed resources are those that belong to an applicant's spouse, parent, parent's spouse, sponsor of a non-citizen, or sponsor's spouse, which are "deemed" by the administration as belonging to the applicant. While multiple types of resources are considered for eligibility, many are not. Non-countable (excluded) resources are listed below.

The following resources are not counted toward the SSI resource standard:

- The home an applicant lives in and the land it is on[1]
- 1 vehicle, regardless of value, if an applicant or a member of their household uses it for transportation
- Household goods and personal effects (e.g., wedding rings and engagement rings)
- Life insurance policies with a combined face value of $1,500 or less
- Burial spaces for the applicant and their immediate family
- Burial funds for the applicant and their spouse, each valued at $1,500 or less
- Property that an applicant or their spouse trades in business, or on the job if they work for someone else
- Money or property an applicant has set aside under a Plan to Achieve Self-Support, if the applicant is blind or disabled
- Up to $100,000 of funds in an Achieving a Better Life Experience (ABLE) account established through a state ABLE program
- Retroactive SSI or Social Security benefits for up to 9 months after an applicant receives them (including payments received in installments)
- Grants, scholarships, fellowships, or gifts set aside to pay educational expenses for 9 months after receipt
- Money saved in an Individual Development Account
- Support and maintenance assistance and home energy assistance that the administration does not count as income
- Cash received for medical or social services that the administration does not count as income is not a resource for 1 month
    - ◇ EXCEPTION: Cash reimbursements of expenses already paid for by the applicant are evaluated under the regular income and resources rules
- Health flexible spending arrangements
- State or local relocation assistance payments are not counted for 9 months
- Crime victim's assistance is not counted for 9 months
- Earned income tax credit payments are not counted for 12 months
- Dedicated accounts for disabled or blind children
- Disaster relief assistance which the administration does not count as income
- Cash received for the purpose of replacing an excluded resource (for example, a house) that is lost, damaged, or stolen is not counted for 9 months
- All Federal tax refunds and advanced tax credits received on or after January 1, 2010 are not counted for 12 months
- The first $2,000 of compensation received per calendar year for participating in certain clinical trials
- Some trusts, including special needs trusts, pooled trusts, and if an applicant meets undue hardship criteria

Source: SSA (2025c)

Notes: [1] After the passage of the Deficit Reduction Act of 2005, states were required to implement a home equity limit for individuals seeking Medicaid long-term care. This is a separate threshold that makes an individual ineligible for long-term care if they have an equity interest in their home that is greater than the excess home equity limit. See Table 9 in Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025 for historical home equity limits.

Table 3: Washington Spousal Impoverishment Standards (1992–2025)

Year	Minimum MMNA	Maximum MMNA	Minimum CSRA (state)	Maximum CSRA (fed)
1992	$984.20	$1,718.00	N/A	$68,700
1993	1,148.75	1,769.00	N/A	70,740
1994	1,178.75	1,817.00	N/A	72,660
1995	1,230.00	1,871.00	N/A	74,820
1996	1,253.75	1,919.00	N/A	76,740
1997	1,295.00	1,976.00	N/A	79,020
1998	1,326.25	2,019.00	N/A	80,760
1999	1,357.00	2,049.00	N/A	81,960
2000	1,382.50	2,103.00	N/A	84,120
2001	1,406.25	2,175.00	N/A	87,000
2002	1,451.25	2,232.00	N/A	89,280
2003	1,492.50	2,266.50	40,000	90,660
2004	1,515.00	2,319.00	40,000	92,760
2005	1,561.25	2,377.50	41,943	95,100
2006	1,604.00	2,489.00	41,943	99,540
2007	1,650.00	2,541.00	45,104	101,640
2008	1,711.25	2,610.00	45,104	104,400
2009	1,750.00	2,739.00	48,639	109,560
2010	1,821.25	2,739.00	48,639	109,560
2011	1,838.75	2,739.00	48,639	109,560
2012	1,891.25	2,841.00	48,639	113,640
2013	1,939.00	2,898.00	53,016	115,920
2014	1,966.25	2,931.00	53,016	117,240
2015	1,991.25	2,981.00	54,726	119,220
2016	2,002.50	2,981.00	54,726	119,220
2017	2,030.00	3,023.00	55,547	120,900
2018	2,057.00	3,090.00	55,547	123,600
2019	2,113.75	3,160.50	58,075	126,420
2020	2,155.00	3,259.50	58,075	128,640
2021	2,177.50	3,259.50	59,890	130,380
2022	2,288.75	3,435.00	59,890	137,400
2023	2,465.00	3,715.50	68,301	148,620
2024	2,555.00	3,853.50	68,301	154,140
2025	2,555.00	3,948.00	68,301	157,920

Source: WAC (1992), DSHS (2003), WAC (2003), WSR (2004), DSHS (2006), HCA (2014), CMS (2025b)

Notes: Federal law requires states to set the minimum monthly maintenance needs allowance (MMNA) standard at 150% of the federal poverty level (FPL) for a couple, increasing each year with inflation, except for FY 1992, which was set at 133% of the FPL. MMNAs are calculated using FPLs for each year and are validated by state and federal sources. Some states round to the dollar, which may lead to minor variations between the calculated federal amounts and state-specific standards. For Community Spouse Resource Allowances (CSRAs), the maximum was set at $60,000 as of September 30, 1989, increasing each year with inflation. CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U). Washington state legislation does not document a minimum CSRA amount until 2003, when a state-specific CSRA for individuals who were institutionalized after August 1, 2003 was implemented. This amount was set at $40,000 and increased biennially on July 1 of every odd year. See WSR (2004) for more information.

Table 4: Washington Medicaid Personal Care ADL Assessment Scoring (1993–2004)

Direct personal care task	None/ Independent	Minimal	Substantial	Total
Eating breakfast	0	4	7	10
Eating light meal	0	4	7	10
Eating main meal	0	5	10	15
Toileting	0	5	10	15
Ambulation	0	4	7	10
Transfer	0	1	3	5
Positioning (Bed mobility)	0	1	3	5
Body care	0	5	10	15
Personal hygiene	0	1	3	5
Dressing	0	4	7	10
Bathing	0	4	7	10
Self-administration of medication/ med management	0	2	4	6
Travel to medical services	0	1	2	3
Essential shopping with client	0	5	10	15
Essential shopping for client	0	1	3	5
Meal preparation - Breakfast	0	4	7	10
Meal preparation - Light meal	0	4	7	10
Meal preparation - Main meal	0	5	10	15
Laundry facilities in home	0	1	2	3
Laundry facilities out of home	0	3	5	7
Housework	0	1	2	3
Wood supply	0	3	5	7

Source: WAC § 388-15-203 (1993), WAC § 388-15-203 (1996)

Notes: From 1993, Washington legislation documents a scale used to determine the amount and duration of MPC services. Scores are provided based on the level of assistance an individual requires to complete each direct personal care task, detailed in the table above. Levels of assistance include none/independent (I), minimal (M), substantial (S), and total (T). See Table 6 and Table 7 in Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025 for definitions of levels of assistance. See Table 5 in Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025 to learn how these scores are totaled and converted to a maximum number of MPC service hours an individual may receive each month.

From 1996, only activities of daily living were used to determine eligibility for MPC, but all direct personal care tasks continued to be assessed to inform the plan of care, and the existing scoring system continued to be used to calculate the amount and duration of services.

Table 5: Washington Medicaid Personal Care Maximum Service Hours (1993–2004)

Activities of Daily Living (ADL) assistance score range	Maximum monthly hours of service
1-4	5
5-9	8
10-14	11
15-19	14
20-24	18
25-29	21
30-34	24
35-39	28
40-44	31
45-49	34
50-54	37
55-59	41
60-64	44
65-69	47
70-74	51
75-79	54
80-84	57
85-89	60
90-94	64
95-99	67
100-104	70
105-109	74
110-114	77
115-119	80
120-124	83
125-129	87
130-134	90
135-139	93
140-144	97
145-149	100
150-154	103
155-159	106
160-164	110
165-169	113
170 and above	116

Source: WAC § 388-15-203 (1993), WAC § 388-15-203 (1996)

Notes: From 1993, Washington legislation documents a scale used in the standardized care needs assessment for MPC. Scores are provided based on the level of assistance an individual requires to complete a direct personal care task. See Table 4 in Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025 for direct personal care task scores. Levels of assistance include independent (I), minimal (M), substantial (S), and total (T) . See Table 6 and Table 7 in Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025 for definitions of levels of assistance. These scores are converted to a maximum number of MPC service hours an individual may receive each month, detailed in the table above.

From 1996, only activities of daily living were used to determine eligibility for MPC, but all direct personal care tasks continued to be assessed to inform the plan of care, and the existing scoring system continued to be used to calculate the amount and duration of services.

Table 6: Washington Standardized Level of Care Criteria —ADL Levels of Assistance part 1 (1993-2005)

ADL	Level	Description
Ambulation	Independent (I)	Applicant is mobile, with or without an assistive device, both inside and outside the household without the assistance of another person.
	Minimal (M)	Applicant is mobile inside without assistance but needs the assistance of another person outside, or needs occasional assistance from another person inside and usually needs assistance of another person outside.
	Substantial (S)	Applicant is only mobile with regular assistance of another person both inside and outside.
	Total (T)	Applicant is not mobile.
Bathing	Independent (I)	Applicant can bathe self.
	Minimal (M)	Applicant requires oversight help or reminding only. They can bathe without assistance or supervision, but must be reminded some of the time, or cannot get up into the tub alone and physical help is limited to stand-up assist only.
	Substantial (S)	Applicant requires physical help in a large part of the bathing activity, for example, to lather, wash, and/or rinse own body or hair.
	Total (T)	Applicant is dependent on others to provide a complete bath.
Body care	Independent (I)	Applicant can apply ointment, lotion, change bandages or dressings, and perform exercises without assistance.
	Minimal (M)	Applicant requires oversight help or reminding only or requires occasional assistance.
	Substantial (S)	Applicant requires limited physical help to apply ointment, lotion, or to perform dry bandage or dressing change.
	Total (T)	Applicant is dependent on others to perform all required body care.
Dressing	Independent (I)	Applicant can dress and undress without assistance or supervision.
	Minimal (M)	Applicant can dress/undress, but may need to be reminded or supervised on some days; or can assist dressing/undressing but needs some phyiscal assistance frequently/most of the time.
	Substantial (S)	Applicant always needs assistance to do parts of dressing and undressing.
	Total (T)	Applicant is dependent on others to do all dressing and undressing.
Eating	Independent (I)	Applicant can feed self, chew and swallow solid foods without difficulty, or can feed self by stomach tube or catheter.
	Minimal (M)	Applicant: (A) can feed self, chew and swallow foods, but needs reminding to maintain adequate intake, (B) may need food cut up, or (C) can feed self only if food is brought to them.
	Substantial (S)	Applicant can do 1 of the following: (A) feeds self but needs standby assistance for occasional gagging, choking, or swallowing difficulty (B) needs reminders/ assistance with adaptive feeding equipment, or (C) must be fed some or all food by mouth by another person.
	Total (T)	Applicant must be totally fed by another person and/or frequently gags or chokes due to difficulty in swallowing, or applicant must be fed by another person by stomach tube or by venous access.

Sources: WAC § 388-15-203 (1993), WAC § 388-15-203 (1996)

Notes: Washington created standardized definitions for levels of assistance needed with activities of daily living (ADLs) that were used to determine eligibility for MPC, nursing facility care, and COPES. While definitions for levels of care apply to all programs, eligibility criteria differs by program, and not all programs consider every ADL listed as part of their functional assessment criteria. See the *Care Needs Assessment* section for more details. Levels of assistance needed with ADLs are ranked using the following 4-point scale: independent (I), minimal (M), substantial (S), and total (T).

Table 7: Washington Standardized Level of Care Criteria—ADL Levels of Assistance part 2 (1993-2005)

ADL	Level	Description
Personal Hygiene	Independent (I)	Applicant can manage personal hygiene and grooming tasks on a regular basis.
	Minimal (M)	Applicant can manage their personal hygiene/grooming but must be reminded or supervised at least some of the time; or regularly requires some limited assistance with both activities.
	Substantial (S)	Applicant requires regular assistance with personal hygiene/grooming and cooperates in the process.
	Total (T)	Applicant is dependent on other to provide all personal hygiene and grooming.
Positioning	Independent (I)	Applicant can move to and from a lying position, position their body in bed, and get into and out of bed and chairs.
	Minimal (M)	Applicant can move to and from a lying position, turn from side to side, and position their body while in bed and chairs but requires assistance some of the time.
	Substantial (S)	Applicant needs occasional assistance to move to and from a lying position, turn from side to side, and position body while in bed and chairs.
	Total (T)	Applicant needs assistance most or all of the time to move to and from a lying position, turn from side to side, and position body while in bed and chairs.
Self-medication	Independent (I)	Applicant can take own medications or does not take medication.
	Minimal (M)	Applicant is physically able to take medications but requires another person to either: (A) remind, monitor, or observe the taking of medications less than daily, or (B) open a container, lay out, or organize medications less than daily.
	Substantial (S)	Applicant can physically take medications, but requires another person to either remind, monitor, or observe the taking of medications daily; or can physically take medications if another person daily opens containers, lays out, organizes medications.
	Total (T)	Applicant cannot physically take medications and requires another person to assist and administer all medications.
Toileting	Independent (I)	Applicant can use the toilet without physical assistance or supervision, can manage own closed drainage system if the system has a catheter or sheath, or uses and manages protective aids. Applicant may need grab bars or raised toilet seat.
	Minimal (M)	Applicant needs stand-by assistance for safety or encouragement. They may need minimal physical assistance with parts of the task, such as clothing adjustment, washing hands, wiping, and cleansing. Applicant may need a protective garment and may or may not be aware of this need.
	Substantial (S)	Applicant cannot get to the toilet without assistance, needs substantial physical assistance with part of the task, or needs someone else to manage care of a closed drainage system if it has a catheter or sheath. Applicant may or may not be aware of own needs.
	Total (T)	Applicant is physically unable to use toilet. Requires continual observation and total cleansing. They may require protective garments or padding or linen changes and may or may not be aware of own needs.
Transfer	Independent (I)	Applicant can transfer without physical assistance.
	Minimal (M)	Applicant transfers without physical assistance most of the time but needs assistance on occasion.
	Substantial (S)	Applicant can assist with own transfers but frequently or most of the time needs assistance.
	Total (T)	Transfers must be done by someone else.

Sources: WAC § 388-15-203 (1993), WAC § 388-15-203 (1996)

Notes: Washington created standardized definitions for levels of assistance needed with activities of daily living (ADLs) that were used to determine eligibility for MPC, nursing facility care, and COPES. While definitions for levels of care apply to all programs, eligibility criteria differs by program, and not all programs consider every ADL listed as part of their functional assessment criteria. See the *Care Needs Assessment* section for more details. Levels of assistance needed with ADLs are ranked using the following 4-point scale: independent (I), minimal (M), substantial (S), and total (T).

Box 2: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 3: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: Mass.gov (1999), UCSF (2023)

Box 4: Washington Medicaid Major Changes to Estate Recovery Rules (1992–2014)

As required by federal law, Washington enforces Estate Recovery. Below is a summary of notable changes to estate recovery rules implemented from 1992–2014:

- (1992-July 1, 1994) Individuals are liable for estate recovery for any Medicaid services rendered after age 65
- (July 1, 1994-June 30, 1995) Individuals are liable for nursing facility care, home and community-based services (HCBS), and related hospital or prescription drug services provided after the individual turned 55
- (July 1, 1995-May 31, 2004) Individuals are liable for nursing facility care, HCBS, and related hospital or prescription drug services, plus an extended list of state-plan long-term care services including adult day health, and Medicaid personal care (MPC) services provided after the individual turned 55
- (June 1, 2004-December 31, 2013) Individuals are liable for estate recovery for any Medicaid services rendered after age 55
- (From January 1, 2014) Individuals are liable for estate recovery for all Medicaid long-term care services including nursing facility care, MPC, HCBS (e.g. COPES and Community First Choice - CFC), private duty nursing, and related hospital and prescription drug services provided after the individual turned 55

Source: WAC § 388-527-2742 (2025)

Table 8: Washington Personal Needs Allowances (PNA) (1992–2025)

Year	PNA (monthly)
1992	$38.84
1993-2004	41.62
2005	51.62
2006	53.68
2007	55.45
2008-2017	57.28
2018	58.43
2019-2020	70.00
2021	71.12
2022	75.36
2023	100.00
2024	103.20
2025	105.78

Source: WAC (1993), WSR (2007), WAC (2009), LTC Ombudsman (2010), HCA (2011-2025)
Notes: Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). Authors have not yet verified the PNA amounts for fiscal years (FY) 1994 and 2004 because the administrative codes regarding PNAs for these years were not published.

Table 9: Washington Home Equity Limits (2006–2025)

Year	Home equity limit
2006	$500,000
2007	500,000
2008	500,000
2009	500,000
2010	500,000
2011	506,000
2012	525,000
2013	536,000
2014	543,000
2015	552,000
2016	552,000
2017	560,000
2018	572,000
2019	585,000
2020	595,000
2021	603,000
2022	955,000
2023	1,033,000
2024	1,071,000
2025	1,097,000

Source: WSR (2011a), Medicaid.gov (2022), HCA (2023), SSA (2024b)
Notes: The limit was $500,000 from January 2006 to 2011, after which the equity limit began increasing annually with inflation. Home equity limits are calculated using Social Security Cost-of-Living Adjustments (COLAs) and are validated by state and federal sources. In 2022, Washington elected to set the home equity limit to the federal maximum of $955,000, increasing annually with inflation. Previously, Washington set the home equity limit to the federal minimum.

Table 10: Washington CARE Assessment Medicaid Personal Care (MPC) Functional Eligibility Criteria (2003–2025)

A. Applicants to MPC must have 1 of the following:	B. Self-performance threshold	C. Support provided threshold
(1) Unmet or partially met need with at least 3 ADLs:[1]		
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Transfers	Supervision	Setup
Bed Mobility	Supervision	Setup
Walking/locomotion in room, or locomotion outside	Supervision	Setup
Medication Management	Assistance required	N/A
Dressing	Supervision	N/A
Personal hygiene	Supervision	N/A
Body care	Needs or received assistance applying ointments/ lotion, trimming of toenails, dry bandage changes, or passive range-of-motion treatment	
(2) Unmet or partially met need (or activity did not occur due to no provider available, or applicant was unable) with at least 1 ADL:		
Eating	Supervision	1-person physical assist
Toileting	Extensive assistance	1-person physical assist
Bathing	Limited assistance [2]	1-person physical assist
Transfers	Extensive assistance	1-person physical assist
Bed mobility and turning/ repositioning	Limited assistance and need	1-person physical assist
Walking/locomotion in room, or locomotion outside	Extensive assistance	1-person physical assist
Medication management	Assistance required daily	N/A
Dressing	Extensive assistance	1-person physical assist
Personal hygiene	Extensive assistance	1-person physical assist
Body care	Needs or received assistance applying ointments/ lotion, trimming of toenails, dry bandage changes, or passive range-of-motion treatment	

Source: WSR (2003b), WSR (2005), WAC § 388-106-0355 (2025)

Notes: From 2003, individuals are assessed using the Comprehensive Assessment Reporting Evaluation (CARE) to determine eligibility for LTC services, however, thresholds for eligibility vary by LTC program. This table details eligibility criteria for Medicaid Personal Care (MPC), which is dependent on ability to complete activities of daily living (ADLs). Applicants must meet the thresholds in columns B and C for the respective ADLs in column A in order to be eligible. In column A, the applicant only needs to satisfy the thresholds for (1) or (2), not both.

CARE characterizes an individual's unmet needs performing ADLs using 2 categories of assistance: self-performance and support provided. Self-performance characterizes the applicant's actual ability to perform ADLs within the 7 days prior to the level of care assessment, not what they might be capable of doing. Support provided refers to the highest level of support with ADLs provided to the applicant in the 7 days prior to the level of care assessment, even if the support was only provided 1 time. See Table 12 for definitions of levels of self-performance and support provided.

[1] From March-November 2003, applicants had to have an unmet or partially met need with at least 1 ADL using thresholds for (1). From December 2003, individuals could become eligible for MPC by satisfying criteria for (1) or (2).

[2] For bathing, "limited assistance" refers to requiring physical help with transferring only.

Table 11: Washington CARE Assessment and Nursing Facility Level of Care Eligibility Criteria —Activities of Daily Living Pathways (2003–2025)

A. Activities of daily living (ADL)-dependent pathway	B. Self-performance threshold	C. Support provided threshold
(1) Unmet or partially met need with at least 3 ADLs:		
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Transfers	Supervision	Setup
Bed Mobility	Supervision	Setup
Walking/locomotion in room, or locomotion outside	Supervision	Setup
Medication Management	Assistance required	N/A
(2) Unmet or partially met need with at least 2 ADLs:		
Eating	Supervision	1-person physical assist
Toileting	Extensive assistance	1-person physical assist
Bathing	Limited assistance (transfer)	1-person physical assist
Transfers	Extensive assistance	1-person physical assist
Bed mobility and turning/ repositioning	Limited assistance	1-person physical assist
Walking/locomotion in room, or locomotion outside	Extensive assistance	1-person physical assist
Medication management	Assistance required daily	N/A
(3) Requires supervision due to a cognitive impairment and meets the criteria for at least 1 ADL under pathway (2)		

Source: WSR (2003a), WSR (2005), WAC § 388-106-0355 (2025)

Notes: From 2003, individuals are assessed using the Comprehensive Assessment Reporting Evaluation (CARE) to determine eligibility for LTC services, however, thresholds for eligibility vary by LTC program. This table details eligibility criteria for a nursing facility level of care (NFLOC), a requirement for Nursing Facility Care, COPES, and CFC (from 2015). To meet an NFLOC, an individual must meet the requirements for at least 1 of 4 pathways detailed in the *Care Needs Assessment* section of the document. Only pathways that are activities of daily living (ADL)-dependent are detailed in this table. Applicants must meet the thresholds in columns B and C for the respective ADLs in column A in order to be eligible. In column A, the applicant only needs to satisfy the thresholds for (1) or (2), not both.

CARE characterizes an individual's unmet needs performing ADLs using 2 categories of assistance: self-performance and support provided. Self-performance characterizes the applicant's actual ability to perform ADLs within the 7 days prior to the level of care assessment, not what they might be capable of doing. Support provided refers to the highest level of support with ADLs provided to the applicant in the 7 days prior to the level of care assessment, even if the support was only provided 1 time. See Table 12 in Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025 for definitions of levels of self-performance and support provided.

Minimum level of assistance thresholds detailed in this table are documented in the state legislation from 2003, however, it is possible that full implementation of these thresholds was not complete until 2005, when all sections documenting old eligibility criteria were officially removed from the Washington Administrative Code.

Table 12: Washington CARE Assessment Nursing Facility Level of Care Eligibility Criteria —Levels of Self Performance and Support Provided for ADLs (2003-2025)

Category	Level	Definitions/ examples (if applicable)
Self Performance	Independent	1 of the following must apply: (i) No help, including oversight, encouragement, or cueing. (ii) Help including oversight, encouragement, or cueing only once or twice in the 7-day period.
	Supervision	If the individual received oversight (monitoring or standby), encouragement, or cueing 3 or more times.
	Limited assistance	If the individual was highly involved in the ADL and received assistance that involved physical, nonweight bearing contact between the individual and the individual's caregiver, or guided maneuvering of limbs 3 or more times. For bathing, limited assistance means physical help is limited to transfer only.
	Extensive assistance	If the individual performed part of the ADL, but on 3 or more occasions, the individual needed weight bearing help or the individual did not participate in a subtask of the ADL, but did participate in other subtasks of the ADL. For bathing, extensive assistance means you needed physical help with part of the activity (other than transfer).
	Total dependence	If the individual did not participate at all in the completion of the ADL. Every time the ADL was completed during the entire 7-day period, the individual received complete assistance of all subtasks completed during the entire 7-day period by others.
	Did not occur	Activity did not occur if the individual or others did not perform an ADL over the last 7 days before the individual's assessment because either the individual was not physically able, no provider was available to assist, or the individual declined assistance with the task.
Support Provided	None	No set-up or physical help provided by others.
	Set-up help only	Characterized by providing individual with articles, devices, or preparation necessary for greater independence in performance of the ADL.
	1-person physical assist	Individual requires physical help from 1 person to perform activity.
	2 or more person physical assist	Individual requires physical help from at least 2 people to perform activity.
	Did not occur	ADL did not occur during the entire 7-day period.

Source: WAC § 388-106 (2007), WAC § 388-106 (2025)

Notes: To qualify for a nursing facility level of care (NFLOC), applicants must meet 1 of 4 pathways detailed in Table 11 of Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025. During the level of care assessment, applicants are evaluated on self-performance for activities of daily living (ADLs) and level of support provided for ADLs within the 7 days prior to the assessment. ADLs assessed include eating, toileting, bathing, transfers, bed mobility (and turning/positioning), walking/locomotion (in room or outside immediate living environment), and medication management.

"Self-performance" characterizes the applicant's actual ability to perform ADLs within the 7 days prior to the level of care assessment, not what they might be capable of doing. "Support provided" refers to the highest level of support with ADLs provided to the applicant in the 7 days prior to the level of care assessment, even if the support was only provided 1 time.

Box 5: Washington CARE Assessment Cognitive Performance Scale Guidelines (2004–2025)

To be eligible for nursing facility care, Community Options Program Entry System (COPES), or Community First Choice (CFC) (from 2015), an individual must meet a nursing facility level of care (NFLOC), as assessed by Comprehensive Assessment Reporting Evaluation (CARE). Individuals may require daily nursing care or meet the requirements for 1 of 3 activity of daily living (ADL)-dependent eligibility pathways detailed in Table 11 of Gateway Policy Explorer: Washington, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2025. Pathways 1 and 2 only require assistance with ADLs, while pathway 3 requires a cognitive assessment and specifies that applicants must have a cognitive impairment requiring supervision due to 1 of the following: disorientation, memory impairment, impaired decision making, and wandering. Below we detail cognitive impairment requirements needed to satisfy pathway 3, as assessed by CARE.

To meet cognitive impairment requirements for NFLOC eligibility pathway 3, an individual must have 1 of the following:

- Disorientation: Require supervision due to disorientation, however, methods for determining this are not detailed in state legislation
- Memory Impairment: Score less than 3 on the mini mental status exam 3-word recall test in CARE
- Impaired Decision-making: Classified as having "poor decisions/unaware of consequences," meaning they require reminders, cues, and supervision in planning, organizing, and correcting daily routines
- Wandering (meets 1 of the following):
  - Wanders without exit seeking daily, and this behavior is not easily altered
  - Wanders with exit seeking either currently or in the past with intervention —the behavior may be classified as easily altered or not easily altered

CARE uses the Cognitive Performance Scale (CPS) to measure cognitive impairment, including memory impairment and decision-making. CPS scores range from 0 (no cognitive impairment) to 6 (severe cognitive impairment). Based on information provided in state legislation, meeting the requirements listed above for memory impairment and decision-making correspond to a CPS score of at least 1, however, authors are unable to confirm an exact threshold.

Scores for wandering are determined using the mood and behaviors section of CARE, where scores are weighted based on frequency and ability to alter a behavior. Based on information provided in state legislation, meeting the requirements listed above for wandering correspond to a behavior score of at least 1, however, authors are unable to determine an exact threshold.

CPS and behavior scores are used in conjunction with other factors to place applicants into classification groups that inform care plan development and determine the maximum number of approved in-home and residential service hours. See WAC §§ 388-106-0115, 388-106-0125 (2025d) for more information on this classification system.

Source: WAC §§ 388-72A-0081, 388-106-0083 (2005), WAC §§ 388-106-0090, 388-106-0100 (2025d)
Notes: To be eligible for nursing facility care, COPES, or CFC, an individual must meet a nursing facility level of care (NFLOC), which means they require daily nursing services or meet 1 of 3 activity of daily living (ADL)-dependent pathways detailed in Table 11. Pathways 1 and 2 only require assistance with ADLs, while pathway 3 also includes a cognitive assessment. This table details how Comprehensive Assessment Reporting Evaluation (CARE) is used to measure cognitive impairment as it relates to meeting an NFLOC under this pathway. While state legislation provides information on cognitive and behavioral assessments, authors are unable to identify exact thresholds required to satisfy each requirement needed to meet this NFLOC pathway.

Box 6: WA Cares Fund (Washington Long-Term Care Insurance)

In 2019, Washington implemented the WA Cares Fund, a universal public long-term care insurance (LTCI) program. Established by the Long-Term Services and Supports Trust Act of 2019, the program provides funds to contributing residents when the need for care arises. It is the first of its kind in the United States.

From July 2023, the following eligibility requirements must be met before the individual can access their benefit:

- Contribute a 0.58% payroll tax for at least 10 years (or less if nearing retirement or have a sudden need)
- Have a care need that requires assistance with activities of daily living (ADLs)

The care need requirement will be met if the individual requires assistance with 3 or more ADLs or has a cognitive impairment and requires supervision to complete at least 1 ADL.

After meeting the care need and contribution requirements, individuals can apply online to access their benefit starting in July 2026. Once approved, they can access up to $36,500 (adjusted for inflation) to pay for care.

Because most long-term care in the United States is provided by Medicaid, the Gateway Long-Term Care Series typically only documents Medicaid long-term care benefit programs in each state. Washington's landmark LTCI program will be documented in a separate policy document available on the Gateway and will not be included in detail here.

Sources: Washington State Legislature, H.B. 1087 (2019); Washington.gov (2025)
Notes: This document provides detailed policy information on Washington's Medicaid long-term care benefits. The WA Cares Fund will be detailed in a separate document and available on the Gateway.

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/policy-explorer).

Centers for Medicare & Medicaid Services (2021). Implementation Guide: Medicaid State Plan Eligibility Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules. As of July 2, 2025. [Link]

Centers for Medicare & Medicaid Services (2025a). Application for 1915(c) HCBS Waiver: WA.0049.R09.01. As of May 21, 2025. [Link]

Centers for Medicare & Medicaid Services (2025b). Spousal Impoverishment. As of July 2, 2025. [Link]

Code of Federal Regulations (1992a). 42 CFR, § 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for mental diseases). EPSDT, and family planning services and supplies. As of June 30, 2025. [Link]

Code of Federal Regulations (2012). 42 CFR § 483.100-138. As of July 1, 2025. [Link]

Code of Federal Regulations (2025). 42 CFR § 435.916 Periodic renewal of Medicaid eligibility. Accessed June 27, 2025. [Link]

Columbia Legal Services (2019). Questions and Answers on the COPES Program. As of May 20, 2025. [Link]

Congressional Research Service (2002). Medicaid: Eligibility for the Aged and Disabled. [Link]

Congressional Research Service (2011). Medicaid Eligibility for Persons Age 65+ and Individuals with Disabilities: 2009 State Profiles [Link]

Congress.gov (2020). H.R. 6201 Families First Coronavirus Response Act. As of July 2, 2025. [Link]

Kaiser Family Foundation (1999). Medicaid Eligibility for the Elderly. As of July 1, 2025. [Link]

Kaiser Family Foundation (2018). Key State Policy Choices About Medicaid Home and Community-Based Services. As of July 1, 2025. [Link]

LTC Ombudsman (2010). Appendix 1: Nursing Home Personal Needs Allowance by State and Year. As of July 2, 2025. [Link]

Mass.gov (1999). Minimum Data Set for Home Care (MDS-HC). As of July 2, 2025. [Link]

Medicaid.gov (2011). Washington State Plan Amendment (SPA) Transmittal Number 11-017. As of May 6, 2025. [Link]

Medicaid.gov (2014) Washington State Plan Amendment (SPA) Transmittal Number 14-0004. As of May 20, 2025 [Link]

Medicaid.gov (2022). Washington State Plan Amendment (SPA) WA-22-0022. As of May 20, 2025 [Link]

Social Security Administration (1998). Noncitizens and the Supplemental Security Income Program. As of July 2, 2025. [Link]

Social Security Administration (2011). State Assistance Programs for SSI Recipients, January 2011 - Washington. As of July 2, 2025. [Link]

Social Security Administration (2024a). Understanding Supplemental Security Income SSI Eligibility Requirements. As of July 2, 2025. [Link]

Social Security Administration (2024b). Social Security Cost-Of-Living Adjustments. As of July 2, 2025. [Link]

Social Security Administration (2025a). SSI Federal Payment Amounts 1975-2025. As of July 2, 2025. [Link]

Social Security Administration (2025b). Supplemental Security Income (SSI) for Noncitizens. As of July 2, 2025. [Link]

Social Security Administration (2025c). Supplemental Security Income (SSI) Resources. As of July 10, 2025. [Link]

Social Security Administration (2025d). Title XIX: Grants to States for Medical Assistance Programs. As of July 2, 2025. [Link]

United States Senate (1996). Resolution Authorizing a Study of the Problems of the Aged and Aging. As of July 2, 2025. [Link]

University of California San Francisco (2023). Minimum Data Set (MDS) Data. As of July 2, 2025. [Link]

U.S. Congress. (1996). Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (H.R.3734). § 104-193. Enacted August 22, 1996. [Link]

U.S. Department of Health and Human Services (2023). State Federal Medical Assistance Percentages. As of July 2, 2025. [Link]

Washington Administrative Code (1992). Title 388 - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (1993). Title 388 Supplement - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (1996). Title 388 Supplement - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (1997a). Title 388A - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (1997b). Title 388B - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2001). Title 388B - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2003). Title 388B - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2004). Title 388 Supplement - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2005). Title 388 - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2006). Title 388 Supplement - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2007). Title 388B - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2008). Title 388 Supplement - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2009). Title 388B - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2014a). Title 182, Chapter 515. Alternate Living - Institutional Medical. As of May 21, 2025. [Link]

Washington Administrative Code (2014b). Title 388 - Department of Social and Health Services (Public Assistance) [Link]

Washington Administrative Code (2016) Title 388, Chapter 106 - Long-Term Care Services. [Link]

Washington Administrative Code (2024). Title 182, Chapter 519. Medically Needy and Spenddown. As of July 8, 2025. [Link]

Washington Administrative Code (2025a) Title 182, Chapter 501. Health care coverage - Program benefit packages - Scope of Service Categories. As of May 21, 2025. [Link]

Washington Administrative Code (2025b) Title 182, Chapter 527. Estate Recovery. As of May 21, 2025. [Link]

Washington Administrative Code (2025c). Title 388, Chapter 97. Nursing Homes. As of May 21, 2025. [Link]

Washington Administrative Code (2025d). Title 388, Chapter 106. Long-term care services. As of May 21, 2025. [Link]

Washington Department of Social and Health Services (2003). HCS Management Bulletin 03-45. As of May 21, 2025. [Link]

Washington Department of Social and Health Services (2006). Medical Assistance Eligibility Overview. Retrieved from Washington Digital Archives on April 8, 2025. [Link]

Washington Department of Social and Health Services (2009). Medical Assistance Eligibility Overview. Retrieved from Washington Digital Archives on April 8, 2025. [Link]

Washington Department of Social and Health Services (2015a). HCS Management Bulletin H15-028. [Link]

Washington Department of Social and Health Services (2015b). Management Bulletin H15-052. [Link]

Washington Department of Social and Health Services (2016) HCS Management Bulletin H16-065. [Link]

Washington Department of Social and Health Services (2017) HCS Management Bulletin H17-003. [Link]

Washington Department of Social and Health Services (2019) HCS Management Bulletin H19-012. [Link]

Washington Department of Social and Health Services (2022) HCS Management Bulletin H22-059. [Link]

Washington.gov (2025). WA Cares Fund: How the Fund Works. As of June 9, 2025. [Link]

Washington State Health Care Authority (2011). HCA Medical Income and Resource Standards. As of May 21, 2025. [Link]

Washington State Health Care Authority (2014). HCA Medical Income and Resource Standards. As of May 21, 2025. [Link]

Washington State Health Care Authority (2021). Medicaid Personal Care. As of June 13, 2025. [Link]

Washington State Health Care Authority (2023). Program standard for income and resources. As of May 21, 2025. [Link]

Washington State Healt Care Authority (2024). State-funded long-term care for noncitizens. As of July 1, 2025. [Link]

Washington State Legislature (2019). H.B. 1087, Concerning long-term services and supports. 66th Leglislature, 2019 Regular Session. As of July 1, 2025. [Link]

Washington State Register (2003a). Register 03-05-097, Department of Social and Health Services. Effective March 17, 2003. [Link]

Washington State Register (2003b). Register 03-24-001, Department of Social and Health Services (Aging and Disability Services Administration). As of July 3, 2025. [Link]

Washington State Register (2004). Register 04-02-013, Department of Social and Health Services. Effective January 1, 2004. As of May 21, 2025. [Link]

Washington State Register (2005). Register 05-11-082, Department of Social and Health Services. Effective June 17, 2005. As of May 19, 2025. [Link]

Washington State Register (2006). Register 06-07-144, Department of Social and Health Services. Effective April 21, 2006. As of July 3, 2025. [Link]

Washington State Register (2007). Register 07-01-072, Department of Social and Health Services. Effective January 18, 2007. As of May 21, 2025. [Link]

Washington State Register (2011a). Register 11-10-038, Department of Social and Health Services. Effective April 27, 2011. As of May 21, 2025. [Link]

Washington State Register (2011b). Register 11-14-075, Health Care Authority. As of April 7, 2025. [Link]

Washington State Register (2015). Register 15-11-049, Department of Social and Health Services. As of June 17, 2025. [Link]

Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Achieving a Better Life Experience (ABLE): Tax-free savings accounts available from December 2014 for individuals with a disability to cover qualified disability expenses. The first $100,000 in this account is not counted when determining eligibility for SSI.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility). In Washington, ADLs are also referred to as "basic self care functions" (before 1996) and "critical self care tasks" (from 1997-2001).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include daytime supervision, social, rehabilitative, recreational, personal care, and sometimes meal services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Adult Family Home: Washington Medicaid state plan benefit for adults who cannot live alone and/or require training, supervision, or assistance with ADLs health-related services. Services may include nursing services if the adult family home is authorized to do so.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Chore Services: Washington state plan benefit providing long-term personal care services at home and occasionally in a community setting while accessing community resources or working. Individuals must have income below 100 percent of the federal poverty level, meet program-specific functional eligibility criteria, and may only receive chore services if they are not eligible for Medicaid Personal Care (MPC) or Community Options Program Entry System (COPES), which are detailed in this document.

Cognitive Performance Scale (CPS): Standardized assessment tool used to evaluate cognitive performance of individuals in need of long-term care. This tool is used in Washington's CARE evaluation, and CPS scores are one component of the state's classification system for determining amount of authorized services.

Community Choice Guide: Service provided to participants of COPES beginning in 2019 which assists individuals who have high turnover in caregivers, have frequent institutional contacts, or are at risk of eviction in their current community setting to establish or stabilize their living situation so they can receive long-term care services at home.

Community First Choice (CFC): State plan option authorized under the Affordable Care Act that allows states to provide expanded home and community-based services (HCBS) through the state plan to individuals with a nursing facility level of care. In Washington, CFC was passed into law in 2014 and was implemented across the state in 2015. All Washington Medicaid beneficiaries that meet the level of care requirements, including COPES participants, may receive services available under CFC provided there is no duplication of services. CFC is an optional state plan program providing a package of state plan long-term care benefits, while COPES is a separate program providing benefits to a limited group of eligible individuals.

Community Options Program Entry System (COPES): Home and community-based services program providing services to adults age 65 or older or 18-64 with a disability who can reside safely in the community. Applicants must meet a nursing facility level of care to be eligible, and must require at least 1 program service per month.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets retained for a beneficiary's spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care. The federal government sets a minimum and maximum community spouse resource allowance (CSRA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington state legislation does not document a minimum CSRA amount until 2003, when a state-specific CSRA for individuals who were institutionalized after August 1, 2003 was implemented. This amount was set at $40,000 and increased biennially on July 1 of every odd year. See WSR (2004) for more information.

Community Supports—Goods and Services: Service provided to participants of COPES beginning in 2019 which provides financial assistance for transitional services when an individual transfers from a residential facility back into the community.

Comprehensive Assessment Reporting Evaluation (CARE): Standardized assessment tool used to determine functional eligibility for long-term care services under Medicaid from 2003. CARE is used to evaluate applicants for all long-term care programs detailed in this document, including MPC, Nursing Facility Care, COPES, and CFC.

Congregate Care: Washington Medicaid state plan benefit for individuals who are unable to live independently in the community or may require assistance with activities of daily living, health related services, personal care, and/or supervision. Congregate care facilities are shared, affordable living for older adults and individuals with disabilities. Living arrangements include private bedroom and shared amenities including restrooms, kitchens, and dining space.

Consumer-directed: Care delivery option that allow Medicaid long-term care beneficiaries to choose, manage, and direct attendants (referred to as individual providers) of their choice to provide personal care services. Additionally, some HCBS program services may

be consumer-directed.

Deficit Reduction Act of 2005: Federal legislation that established home equity limits. Washington implemented a home equity limit of $500,000 beginning in 2006. From 2011, this amount increased annually with inflation. From 2022, Washington aligned the state home equity limit with the federal maximum, which was $955,000. See Medicaid.gov (2022) for more information.

Department of Social and Health Services (DSHS): Washington state department that administers social services including Medicaid to low-income individuals. Until 2011, DSHS was the single state agency for Medicaid.

Direct Personal Care Tasks: A combination of activities of daily living (ADLs) and instrumental ADLs (IADLs) covered under Medicaid Personal Care (MPC). From 1993, applicants must require assistance with at least 1 direct personal care tasks to be eligible for MPC. Direct personal care tasks include personal hygiene, dressing, bathing, eating, toileting, ambulation, transfers, positioning, body care, self-medication, travel to medical services (until 1996) and essential shopping (until 1996). From 1996, we refer to direct personal care tasks as "ADLs" in this document. IADLs like travel to medical services, essential shopping, meal preparation, housework, laundry, and wood supply continued to be assessed after 1996 and were used to inform the individual's care plan, but assistancce with IADLs was not a requirement for MPC eligibility.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300% of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100% of the FPL would qualify based on financial eligibility.

Flexible Spending Arrangement (FSA): Employer-sponsored tax-free savings account for qualified medical expenses. Money in FSAs is not counted when determining eligibility for SSI.

Home Health Agency: Main provider of long-term home health services including skilled nursing services from registered nurses (RN) or licensed practical nurses (LPN), homemaking and personal care services provided by home health aides, and physical or occupational therapy provided by therapists.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Household Assistance: In-home support service available to eligible washington Medicaid beneficiaries that provides assistance with general household activities like meal preparation, laundry, and housekeeping.

Individual Development Account (IDA): Special savings account an individual contributes to using earnings from work. Savings may contribute to education expenses, purchase of a first home, or starting a business. Money saved in IDAs is not counted when determining eligibility for SSI.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Long-Term Care Insurance (LTCI): Privately-funded health insurance that specifically covers LTC services. Many state Medicaid programs, including Washington, have partnerships with private LTCI companies that incentivize purchase of LTCI and provide some financial protection for beneficiaries, including protection from excessive inflation in insurance policy prices. In 2019, Washington created the first ever state-funded LTCI program in the United States, called the WA Cares Fund.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services and HCBS through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid Personal Care (MPC): Washington state plan home care benefit providing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to categorically needy adults who are community-dwelling. Individuals may not be eligible for MPC if they meet a nursing facility level of care.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available. From 2014, Washington's Medicaid state plan is known as Washington Apple Health.

Medical necessity: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy Income Limit (MNIL): The income standard that a Medicaid applicant must spend-down to meet if they are seeking

Medicaid eligibility through eligibility track 3a (Medically needy aged, blind, or disabled). Typically, this standard is very low.

Medically Needy In-home Program: Washingotn home and community-based services (HCBS) program offered from 2007-2012 which provided long term care services to individuals age 65 or older, or age 18-64 with a disability who meet a nursing facility level of care (NFLOC) and live at home in the community.

Medically Needy Residential Program: Washington home and community-based services (HCBS) program offered from 2002-2012 which provided long term care services to individuals age 65 or older, or age 18-64 with a disability who meet a nursing facility level of care (NFLOC) and live in a residential facility other than a nursing home (e.g., adult family home, boarding home).

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Minimal Assistance (M): Level of assistance used to determine functional eligibility for long-term care using the standardized Washington state assessment and CARE until 2005. Generally characterized by the individual requiring reminders and cueing to complete a direct personal care task/ activity of daily living on their own.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Upper limit on countable income retained for a beneficiary's spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care. The federal government sets a minimum and maximum maintenance needs allowance (MMNA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington uses the federal minimum as a standard figure.

New Freedom Program: Washington home and community-based services (HCBS) program offered from 2005 which provides long term care services to individuals age 65 or older, or age 18-64 with a disability who meet a nursing facility level of care (NFLOC) and live at home in the community. This program is only available to residents of select counties across the state.

Nurse Delegation: Service option under Washington Medicaid allowing registered nurses to delegate tasks that are usually only permitted to be performed by a licensed nurse (e.g., prescription medication administration or blood glucose testing) to nursing assistants or home care aides. This service is covered under the COPES program.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Nursing services: Nursing services provided under MPC in Washington include non clinical procedures like assessments/reassessments, care coordination, referral to other health care providers, file review, evaluation of care needs that affect service planning, and provision of instructions to the beneficiary and their providers. Physician-ordered skilled services performed by a nurse (e.g., medication administration or wound care/debridement) are included only in emergency situations. Skilled services are referred to appropriate health care providers, home health agencies, or another source in non-emergency situations.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk

of institutionalization to secure help in an emergency.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Plan to Achieve Self-Support (PASS): A written plan of action for getting a particular kind of job or starting a business which includes information about the job or type of business, steps taken to achieve the work goal, money used to pay for these things, and a timeline for achieving the goal. If an individual is approved for PASS, money spent on their plan will not be counted when determining eligibility for SSI. If the individual is already eligible for SSI, having a PASS will increase their SSI payment, replacing all the money the individual spends on their PASS.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Private Duty Nursing: Washington state plan benefit that provided continuous skilled nursing services (nursing sessions must last at least 4 hours) in an individual's home if the individual has complex needs that exceed the scope of home health services.

Program of All-inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. Enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Self-performance: Category of assistance in the Comprehensive Assessment Reporting Evaluation (CARE) used to evaluate eligibility for long-term care services. Self-performance is characterized by the applicant's actual ability to perform ADLs within the 7 days prior to the level of care assessment, not what they might be capable of doing. The scale used for self-performance includes: independent, supervision, limited assistance, extensive assistance, and total assistance. See Table 8 for more information.

Skilled Services: Skilled nursing care consists of those services that must, under state law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more. Under MPC, these services are only provided in an emergency and are not included in long-term benefits.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Substantial Assistance (S): Level of assistance used to determine functional eligibility for long-term care using the standardized Washington state assessment and CARE (until 2005). Generally characterized by an individual requiring hands-on assistance to complete a direct personal care task/ activity of daily living.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Support Provided: Category of assistance used in the Comprehensive Assessment Reporting Evaluation (CARE) to evaluate eligibility for

long-term care services. Support provided refers to the highest level of support with ADLs provided to the applicant in the 7 days prior to the level of care assessment, even if the support was only provided 1 time. This does not include the applicant's ability to perform an ADL. See Table 8 for more information.

Total Assistance (T): Level of assistance used to determine functional eligibility for long-term care using the standardized Washington state assessment and CARE until 2005. Generally characterized by the individual being completely incapable of completing a direct personal care task/activity of daily living without the assistance of another person.

WA Cares Fund: Washington state public assistance program that allows individuals to contribute to a personal fund while they are in the workforce for later use when they are in need of long-term care, up to $100 per day with a maximum benefit of $36,5000. Individuals were eligible to contribute to their WA Cares Fund beginnning July 2023, and the first payout of benefits to recipients is scheduled for 2026. See WA.gov (2025) for more information.

Washington State Health Care Authority (HCA): Single state agency administering Medicaid in Washington, from 2011. Prior to 2011, Medicaid was administered by the Department of Social and Health Services.

Wellness Education: Personally tailored newsletter service provided to participants of COPES from 2015 which educates participants on relevant health conditions, informs participants how to meet the goals on their service plan, and encourages community living.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement and by region of the state (detailed in the legislation as Area I and Area II). Receipt of this payment will marginally increase the income limit under this track. See WAC (1994), WAC (2005), and SSA (2011) for more information.
2. The look back period is 30 months prior to the date of application for all assets. From 1993, the look back period is 36 months prior to the date of application for all assets and 60 months for a trust. See WAC (1993) for more information. A period of ineligibility ranging from 1-48 months is determined based on the amount of assets transferred.
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
4. Individuals who do not meet the citizenship/immigration standards listed may still be eligible for long-term care coverage in Washington. See HCA (2024) for more information.
5. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024d) for more information on these requirements.
6. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The federal government sets a minimum and maximum maintenance needs allowance (MMNA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington uses the federal minimum as a standard figure, which was $984.20 per month in 1992. This standard increases annually with inflation. When calculating the MMNA, the institutionalized spouse and community spouse's incomes are considered separate. If the community spouse's income is less than this amount, they may allocate from the institutionalized spouse's income up to the MMNA. The MMNA is a post-eligibility calculation used to determine the amount of income the institutionalized spouse has available to pay for the cost of their care. Some states chose to extend spousal impoverishment rules to individuals receiving home and community-based services (HCBS), such as the Aged and Disabled program. In 2014, this became mandatory. Authors were unable to identify whether Washington extended these rules to HCBS prior to 2014. Because Washington allowed individuals in the Aged and Disabled program to use the institutional eligibility track from 1992, it is possible that they also extended spousal impoverishment disregards in 1992 as well. See Table 3 for historical MMNAs.
7. Spousal considerations for assets: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets

up to a certain amount. The federal government sets a minimum and maximum community spouse resource allowance (CSRA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington did not document a minimum CSRA amount from 1992-2002, but used the federal maximum during this period, which was $68,700 in 1992. If the amount is above the minimum, then the state calculates 50% of the couple's combined assets. If 50% of the combined assets is within the range, the spouse may keep this amount. If it is above the maximum amount, the community spouse may only retain up to the maximum amount. Some states chose to extend spousal impoverishment rules to individuals receiving home and community-based services (HCBS), such as the Aged and Disabled program. In 2014, this became mandatory. Authors were unable to identify whether Washington extended these rules to HCBS prior to 2014. Because Washington allowed individuals in the Aged and Disabled program to use the institutional eligibility track from 1992, it is possible that they also extended spousal impoverishment disregards in 1992 as well. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

8. The Gateway Long-Term Care policy series typically includes Home Health as a major program of interest. However, due to explicit language in the Washington statutes defining home health services as short-term, we have chosen to omit this program. Other home and community-based programs in Washington include Home Health as a covered long-term care service if the needs of the participant exceed the scope and duration of the state plan home health benefit. See WAC § 388-182-2000 (2025) for more information.

9. Home health services, including skilled nursing services and home health aide services, were not listed as covered services under COPES from 1993-1995. From 1996, skilled nursing services and home health aide services were added back to the list of services covered under COPES.

10. The look back period is 36 months prior to the date of application for all assets and 60 months for a trust. From May 1, 2006, the look back period is 60 months for all assets. A period of ineligibility ranging from 1-48 months is determined based on the amount of assets transferred.

11. From 2006, the equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.

12. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The federal government sets a minimum and maximum maintenance needs allowance (MMNA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington uses the federal minimum as a standard figure, which was $1,492 per month in 2003. This standard increases annually with inflation. When calculating the MMNA, the institutionalized spouse and community spouse's incomes are considered separate. If the community spouse's income is less than this amount, they may allocate from the institutionalized spouse's income up to the MMNA. The MMNA is a post-eligibility calculation used to determine the amount of income the institutionalized spouse has available to pay for the cost of their care. Some states chose to extend spousal impoverishment rules to individuals receiving home and community-based services (HCBS), such as the Aged and Disabled program. In 2014, this became mandatory. Authors were unable to identify whether Washington extended these rules to HCBS prior to 2014. Because Washington allowed individuals in the Aged and Disabled program to use the institutional eligibility track from 1992, it is possible that they also extended spousal impoverishment disregards in 1992 as well. See Table 3 for historical MMNAs.

13. Spousal considerations for assets: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The federal government sets a minimum and maximum community spouse resource allowance (CSRA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington did not document a minimum CSRA amount from 1992-2002, but used the federal maximum during this period. From 2003, Washington implemented a state-specific minimum CSRA of $40,000 which increased biennially on July 1 of every odd year and continued to use the federal maximum CSRA. If the combined assets of the couple are less than the minimum amount, the community spouse may retain all assets. If the amount is above the minimum, then the state calculates 50% of the couple's combined assets. If 50% of the combined assets is within the range, the spouse may keep this amount. If it is above the maximum amount, the community spouse may only retain up to the maximum amount. Some states chose to extend spousal impoverishment rules to individuals receiving home and community-based services (HCBS), such as the Aged and Disabled program. In 2014, this became mandatory. Authors were unable to identify whether Washington extended these rules to HCBS prior to 2014. Because Washington allowed individuals in the Aged and Disabled program to use the institutional eligibility track from 1992, it is possible that they also extended spousal impoverishment disregards in 1992 as well. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

14. The Affordable Care Act (ACA) provides 100% matching funds for newly eligible adults with incomes up to 138% of the Federal Poverty Level between 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely ASPE (2014).

15. The look back period is 60 months prior to the date of application for all assets.

16. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The federal government sets a minimum and maximum maintenance needs allowance (MMNA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington uses the federal minimum as a standard figure, which was $1,966.25 per month in 2014. This standard increases annually with inflation. When calculating the MMNA, the institutionalized spouse and community spouse's incomes are considered separate. If the community spouse's income is less than this amount, they may allocate from the institutionalized spouse's income up to the MMNA. The MMNA is a post-eligibility calculation used to determine the amount of income the institutionalized spouse has available to pay for the cost of their care. Some states chose to extend spousal impoverishment rules to individuals receiving home and community-based services (HCBS), such as the Aged and Disabled program. In 2014, this became mandatory. Authors were unable to identify whether Washington extended these rules to HCBS prior to 2014. Because Washington allowed individuals in the Aged and Disabled program to use the institutional eligibility track from 1992, it is possible that they also extended spousal impoverishment disregards in 1992 as well. See Table 3 for historical MMNAs.

17. Spousal considerations for assets: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The federal government sets a minimum and maximum community spouse resource allowance (CSRA) that increases with inflation, and states may set their own limits either using a standard figure or range as long as it is within the federal range. Washington uses a state-specific minimum CSRA, which was $53,016 in 2014. Washington uses the federal maximum, which was $117,240 in 2014. If the combined assets of the couple are less than the minimum amount, the community spouse may retain all assets. If the amount is above the minimum, then the state calculates 50% of the couple's combined assets. If 50% of the combined assets is within the range, the spouse may keep this amount. If it is above the maximum amount, the community spouse may only retain up to the maximum amount. Some states chose to extend spousal impoverishment rules to individuals receiving home and community-based services (HCBS), such as the Aged and Disabled program. In 2014, this became mandatory. Authors were unable to identify whether Washington extended these rules to HCBS prior to 2014. Because Washington allowed individuals in the Aged and Disabled program to use the institutional eligibility track from 1992, it is possible that they also extended spousal impoverishment disregards in 1992 as well. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

18. Although home health aide services were removed from the COPES program in 2017, participants may still access home health aide services through the Washington Medicaid state plan.

Version information

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- 1.0 (August 2025): First version.