

# APPENDIX K: Emergency Preparedness and Response

**Background:**

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.<sup>i</sup> This appendix may be completed retroactively as needed by the state.

## Appendix K-1: General Information

**General Information:**

A. State: Washington

B. Waiver Title: COPEs

C. Control Number: WA.0049.R08.03

D. Type of Emergency (The state may check more than one box):

<input checked="" type="radio"/>	<b>Pandemic or Epidemic</b>
<input type="radio"/>	<b>Natural Disaster</b>
<input type="radio"/>	<b>National Security Emergency</b>
<input type="radio"/>	<b>Environmental</b>
<input type="radio"/>	<b>Other (specify):</b>

E. **Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state’s mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

1) On February 29<sup>th</sup>, 2020 Governor Jay Inslee declared a state of emergency in response to new cases of COVID-19, directing state agencies to use all resources necessary to prepare for and respond to the outbreak. The risk posed by a virus outbreak depends on factors including how well it spreads between people, the severity of the illness it causes, and the medical or other measures in place to control the impact of the virus (for example, vaccine or treatment medications). There are currently no vaccine or treatment medications that are effective against COVID-19 which is spreading rapidly in several communities in Washington, and the risk of exposure is increasing for people who live in our state. Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure. Those who have had close contact with persons with COVID-19 are at elevated risk of exposure. Travelers returning from affected international locations where community

spread is occurring are at elevated risk of exposure. Our knowledge of COVID-19 is still rapidly evolving. Individuals who are sick are advised to stay home.

2) As of March 10<sup>th</sup>, 2020 there are 162 confirmed cases and 22 total fatalities of COVID-19. This number is expected to grow.

3) AL TSA is in the process of developing emergency plans to assist communities affected by COVID-19.

4) A number of requirements we have committed to in our state plan and waiver applications are dependent on staff and provider ability to perform tasks. Due to the evolving nature of this crisis we may reach a point where we must adjust service delivery methods, suspend home visits, and shift workload priorities due to staff shortages in order to meet immediate health and safety needs.

**F. Proposed Effective Date: Start Date: 2/29/20 Anticipated End Date: 1/31/2021**

**G. Description of Transition Plan.**

Individuals will transition to pre-emergency service status as soon as circumstances allow. Individual needs will be reassessed, as necessary, on a case by case basis following the return to pre-emergency services.

**H. Geographic Areas Affected:**

All

**I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:***

The state is following CDC and the state's Department of Health guidelines, which can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/index.html> and <https://www.doh.wa.gov/Emergencies/Coronavirus>

**Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver**

**Temporary or Emergency-Specific Amendment to Approved Waiver:**

*These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.*

**a. \_\_\_ Access and Eligibility:**

**i. \_\_\_ Temporarily increase the cost limits for entry into the waiver.**

[Provide explanation of changes and specify the temporary cost limit.]

**ii. \_\_\_ Temporarily modify additional targeting criteria.**

[Explanation of changes]

**b. X Services**

**i. X Temporarily modify service scope or coverage.**

[Complete Section A- Services to be Added/Modified During an Emergency.]

**ii. X Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.**

[Explanation of changes]

Implement a temporary increase in the amount and duration for the following services within the waivers, as necessary on a cases by case basis.

COPES:

- Skilled Nursing
- Adult Day Health services
- Specialized Medical Equipment and supplies
- Client Support Training/Wellness Education
- Transportation
- Community Support: Goods and Services
- Home Delivered Meals
- Adult Day Care
- **Community Choice Guiding**

**iii. \_\_\_ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).**

[Complete Section A-Services to be Added/Modified During an Emergency]

**iv. \_\_\_ Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:**

[Explanation of modification, and advisement if room and board is included in the respite rate]:

NA

**v. \_\_\_ Temporarily provide services in out of state settings (if not already permitted in the state’s approved waiver). [Explanation of changes]**

NA

**c. \_\_\_ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.**

NA

**d. X Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).**

**i. X Temporarily modify provider qualifications.**

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Temporarily waive requirements that out of state providers be licensed in Washington when they are licensed by another state Medicaid agency or Medicare.

Temporarily waive timing requirements for initial training and certification requirements and revalidation of waiver provider renewal requirements related to continuing education and recertification during the state of emergency. This applies to home care agencies and Individual Providers in an in-home setting, and long-term care workers in residential settings.

**ii. \_\_\_ Temporarily modify provider types.**

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

NA

**iii. \_\_\_ Temporarily modify licensure or other requirements for settings where waiver services are furnished.**

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

NA

**e. X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]**

The state has discretion, based on the availability of resources, to determine who (DDA, HCS, or AAA Case Managers) is responsible for completing initial assessments and/or reassessments. The State may modify timeframes or processes for completing assessments:

- 1) Case Managers may complete all Initial and reassessments telephonically or via other audio/video options in lieu of face-to-face assessments. If an assessment is done telephonically all components of the CARE assessment will still be completed except the MMSE, which cannot be done over the phone.
- 2) Annual reassessments of level of care that exceeds the 12 month authorization period will remain open and services will continue to allow sufficient time for the case manager to complete the annual reassessment. A reassessment may be postponed for up to one year.

**f. X Temporarily increase payment rates**

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

To effectively respond to the COVID-19 outbreak the state requires the flexibility to adjust providers' rates if deemed necessary to ensure that essential services are available for clients. If deemed necessary, the state may reimburse providers with an additional add-on COVID-19 rate. This may apply to all services available under the approved waiver as determined by the state on a case by case basis when an increased rate is deemed necessary to maintain services due to risk factors associated with COVID-19. Negotiated COVID add-on rates will be based on current market factors and verified additional costs incurred by the provider. The add-on rate will be determined by the state, but may not exceed 25% of the provider's current rate.

**g. X Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.**

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

The State may modify timeframes or processes for completing person-centered service plans:

- 1) Case Managers may complete the person-centered service planning process telephonically or via other audio/video options in lieu of meeting face-to-face.
- 2) Person centered service plans adjustments may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly related to COVID-19 impacts.

**h.    Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]**

NA

**i. \_\_\_ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.**

[Specify the services.]

NA

**j. X Temporarily include retainer payments to address emergency related issues.**

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

The state elects to make retainer payments to adult day health and adult day care providers in instances where the waiver participant is sick due to COVID-19, sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. The retainer time limit will not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bedhold" in nursing facilities. Adult Day Health and Adult Day Care includes the provision of personal care services.

**k. \_\_\_ Temporarily institute or expand opportunities for self-direction.**

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

NA

**l. \_\_\_ Increase Factor C.**

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

NA

**m. x Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]**

Visitors to residential settings may be limited if directed by Public Health Authorities.

## Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

<b>First Name:</b>	Michael
<b>Last Name</b>	Brown
<b>Title:</b>	Section Manager
<b>Agency:</b>	Health Care Authority
<b>Address 1:</b>	628 8 <sup>th</sup> Ave SE
<b>Address 2:</b>	
<b>City</b>	Olympia
<b>State</b>	WA
<b>Zip Code</b>	98504
<b>Telephone:</b>	360-725-1481
<b>E-mail</b>	<a href="mailto:Michael.brown@hca.wa.gov">Michael.brown@hca.wa.gov</a>
<b>Fax Number</b>	360-725-586-9080

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

<b>First Name:</b>	Jamie
<b>Last Name</b>	Tong
<b>Title:</b>	Waiver Program Manager
<b>Agency:</b>	Aging and Long-Term Support Administration
<b>Address 1:</b>	4450 10 <sup>th</sup> Ave SE
<b>Address 2:</b>	
<b>City</b>	Lacey
<b>State</b>	WA
<b>Zip Code</b>	98504
<b>Telephone:</b>	360-725-3293
<b>E-mail</b>	<a href="mailto:Jamie.tong@dshs.wa.gov">Jamie.tong@dshs.wa.gov</a>
<b>Fax Number</b>	360-725-2646

## 8. Authorizing Signature

**Signature:** \_\_\_\_\_/S/\_\_\_\_\_  
 State Medicaid Director or Designee

<b>Date:</b>	4/20/2020
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<b>First Name:</b>	MaryAnne
<b>Last Name</b>	Lindeblad
<b>Title:</b>	Medicaid Director
<b>Agency:</b>	Health Care Authority
<b>Address 1:</b>	626 8 <sup>th</sup> Ave SE
<b>Address 2:</b>	
<b>City</b>	Olympia
<b>State</b>	WA
<b>Zip Code</b>	98504
<b>Telephone:</b>	360-725-1863
<b>E-mail</b>	<a href="mailto:Maryanne.lindeblad@hca.wa.gov">Maryanne.lindeblad@hca.wa.gov</a>
<b>Fax Number</b>	360-586-9551



## Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Specification**

Service Title: **Adult Day Health**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one: Temporary modification to service definition.*

**Service Definition (Scope):** Adult Day Health is a supervised daytime program providing nursing and rehabilitative therapy services to adults with medical or disabling conditions that require the intervention or services of a registered nurse, or a licensed speech therapist, occupational therapist, or physical therapist acting under the supervision of the participant's physician, when required. Services provided are specified in the participant's service plan and encompass both health and social services needed to ensure the optimal functioning of the participant.

Meals provided as part of the Adult Day Health services shall not constitute a full nutritional regime. A skilled nursing or rehabilitative therapy service must be provided by staff operating within their scope of practice under Washington State law and regulation on each service day for which reimbursement is claimed. Transportation between the participant's place of residence and the Adult Day Health site is included as a component of Adult Day Health services and is reflected in the rate paid to the Adult Day Health providers. To ensure duplicate billing does not occur, The P1 system will have a conflict edit that will result if skilled nursing and transportation are authorized at the same time as Adult day health.

For areas in which COVID-19 has closed an Adult Day Health Center, and to ensure continuity of care is maintained for health and safety, services provided by Adult Day Health Centers will be delivered in the client's residence, or through telephonic wellness checks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Adult Day Health center

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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**Provider Qualifications** *(provide the following information for each type of provider):* Same as waiver app, no changes

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

**Verification of Provider Qualifications** Same as waiver app, no changes

Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Service Delivery Method				
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Service Specification				
Service Title:	Transportation			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one: Temporary modification to service definition</i>				
<p>Service Definition (Scope): Service offered in order to enable participants to gain access to waiver and other community services, activities and resources, as specified in the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a)(if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.</p> <p>During the COVID-19 outbreak, transportation may be authorized to transport a client to a safe location when health and safety needs are in jeopardy and alternative transportation is not available. The need will be identified in the service plan.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Taxi		Public Transit
		Individual		
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i> Same as waiver app, no changes				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	


**Verification of Provider Qualifications: same as waiver app, no changes**

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

**Service Delivery Method**

<b>Service Delivery Method</b> same as waiver application, no changes	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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**Service Specification**

Service Title:	Specialized Medical Equipment and Supplies
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*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:  
Temporary modification to service definition*

**Service Definition (Scope):** Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable the participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable/non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

This service also includes maintenance and upkeep of items covered under the service and training for the participant/caregivers in the operation and maintenance of the item. Training may not duplicate training provided in other waiver services.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

During the COVID-19 outbreak, this service will be expanded to allow the purchase of items related to health and safety such as personal protective **equipment** and disinfectant supplies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Medical Equipment and Supply Contractor
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
<b>Provider Qualifications</b> <i>(provide the following information for each type of provider):</i> Same as waiver application, no changes				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
<b>Verification of Provider Qualifications:</b> Same as waiver application, no changes				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Service Delivery Method				
<b>Service Delivery Method</b> Same as waiver application, no changes	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
<b>Service Specification</b>				
Service Title:	Home Delivered Meals			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one: Temporary modification to service definition</i>				

**Service Definition (Scope):** Board of National Academy of Sciences, National Research Council. A unit of service equals one meal. No more than one meal per day will be reimbursed under the waiver. During COVID 19, to ensure the health and safety needs of clients are met, an additional daily meal may be provided. During the COVID-19 emergency, the requirements for dietary guidelines and Recommended Dietary Allowances will be waived.

Home delivered meals are provided to an individual at home and included in the approved plan of care only when the participant is homebound, unable to prepare the meal and there is no other person, paid or unpaid, to prepare the meal. Receiving a meal is more cost effective than having a personal care provider prepare the meal. When a participant's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by restaurants, cafeterias, or caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments. During Covid-19, if none of these alternatives are available, a shelf stable meal may be delivered to the client.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**Provider Specifications**

Provider Category(s) :	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Food Service Vendor

Specify whether the service may be provided by ( <i>check each that applies</i> ):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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**Provider Qualifications:**

Provider Type:	License ( <i>specify</i> )	Certificate ( <i>specify</i> )	Other Standard ( <i>specify</i> )
			Requesting flexibility to waive Title III Home delivered nutritional program standards and Chapter 246-215 WAC (food service)

**Verification of Provider Qualifications** No changes, same as application

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

**Service Delivery Method**

<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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**Service Specification**

Service Title:	Adult Day Care
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*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

**Service Definition (Scope):**

Adult Day Care services provided in an adult day care center include provision of personal care; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours a day in a group setting on a continuing, regularly scheduled basis.

Services also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regime; and programming and activities designed to meet participants' physical, social and emotional needs.

Adult Day Care shall be included in a participant's approved plan of care only when the participant: has mild to moderate dementia and/or is chronically ill or disabled; is socially isolated and/or confused; has significant risk factors when left alone during the day; needs assistance with personal care; and will benefit from an enriched socially supportive experience.

Personal care service hours are reduced 30 minutes for each hour of Adult Day Care service in order to avoid duplication of personal care services since it is assumed that some personal care tasks will be met by Adult Day Care services.

During COVID-19, the provider may be allowed to provide Adult Day Care activities and wellness checks through telephonic or other audio/video options, and may provide a face to face visit to the client's home and provide a meal if needed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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**Provider Specifications**

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Adult Day Care Center

Specify whether the service may be provided by <i>(check each that applies):</i> NA	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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**Provider Qualifications:** no changes to provider qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>

<b>Verification of Provider Qualifications</b>			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
<b>Service Delivery Method</b>			
<b>Service Delivery Method</b> <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed



<sup>i</sup> Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.