



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of Health and Social Services

GOVERNOR'S COUNCIL ON DISABILITIES
& SPECIAL EDUCATION
Patrick Reinhart, Executive Director

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GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

FASD Workgroup

LOCATION

Governor's Council on Disabilities and Special Education
3601 C Street, Suite 740
Anchorage, Alaska

January 12, 2016
3-4:30pm

CALL TO ORDER

Jeanne Gerhardt-Cyrus called the meeting to order at 3:04 pm.

ROLL CALL

Patrick Reinhart, Anna Attla, Barb Chambers, Betsy Chivers, Jeanne Gerhart-Cyrus, Susan Mayer, PJ Hatfield-Bauer, Art Delaune, Michael Baldwin, Teri Tibbett, Jenn Wagaman, Sherrell Holtshouser, Michael Jeffrey, Chris Freczek, Alex Pastorino, Britteny Howell, Christie Reinhardt, Amanda Lofgren.

OLD BUSINESS

Physician regulations – Christie

Dec 10-11 State board of Ed passed our regulation to list FASD as an OHI in DEED regulation, and allows advanced nurse practitioners to diagnose. We're the first in the country for this! Also, nominations are open until Jan 22 for the Inclusive Practice Award at:

<http://dhss.alaska.gov/gcdse/Pages/InclusivePracticeAward.aspx>

Medicaid presentation – Amanda Lofgren

Gave history of the "journey of Medicaid" expansion and reform. These are 2 separate projects. DHSS has sub—contractors to make recommendations. Hope to include primary care, telehealth, data analytics, etc in Medicaid expansion. Stakeholder efforts started in August, report out on Jan 15 on how to redesign the system. May include patient-centered medical homes that give everyone

case management. Health homes target chronic populations that also provide primary care. Also hope to transform behavioral health system from crisis to continuum of care.

Medicaid reform efforts on the 1915 I and k are separate but simultaneous. Last year Trust advisory boards requested look into contractor for 1915 I and k plans to include more Trust beneficiary groups, populations that fall through the cracks. FASD may fall as either a DD, SMI, or TBI. The reforms will be functionality-based. We need to pay attention to the recommended assessment tools.

1915 k = institutional level of care. The 1915 I does not have same requirement. Would likely still keep 1915c waiver for the rest. 2925 I provides HCB services outside of the waiver. No waitlist, and must be statewide, can go up to 300% fed poverty level. Can include substance abuse and mental illness. Can have several different 1915 I plans to target different populations with different service packages. HMA contractors met with stakeholders around state, will be 10 deliverables to review. Statutes, existing services, cost impact analysis, new tools. Likely will not use ICAP anymore. Next coming months they will review tools and propose service packages in July to DHSS. Gives DHSS 6 months to submit their amendment due Jan 1, 2017 to start July 1, 2017.

Advocates need to align because of this fiscal climate. GR and grant programs are at the greatest risk.

Inclusive Choices Council has 11 stakeholders to work on 1915 I and k, with 8 advisory members. Discussion about the 4 Trust beneficiary groups and where FASD may lie. Jenn Wagaman states that it might be good for us to be sure the assessment tools measure executive functioning and not just physical limitations.

Amanda indicates that Oregon used the SIS and is now switching away from it, we might want to find out why. Some states modify or write their own assessment tools. The department cannot add a bunch of new services, so the tool will measure for services that they are prepared to offer. The timing of the various transitions may differ, don't want to rush. Must be a cost-neutral amendment that is submitted to CMS, determined from a cost impact analysis; can be balanced elsewhere, like in primary care, etc.

Only 4 states have done 1915 I and k together. The contractors will look at their tools, international classification of functioning, etc.

Partner Updates

Teri Tibbett – Partnership meets tomorrow, looking at legislative advocacy. Need a long term project to work on.

Barb Chambers – FASDx is busy with 12 diagnoses per month, booked through May.

Jenn Wagaman – ACCA is also busy, working on state engagement.

Betsy Chivers – Medicaid is a big deal, my older clients don't qualify as DD, SMI, or TBI. They can't get the funding for the neuropsychs they need for a diagnosis.

Date & Time of Next Meeting

Tuesday February 9, 2016 @ 3-4:30pm.

Adjournment

The meeting was adjourned at 4:07 pm

Creating Change That Improves the Lives of Alaskans with Disabilities

Medicaid Home and Community-Based Services

The Medicaid program provides low-income individuals access to basic medical care such as mandatory physician services and hospitalization, and if a state elects, optional services such as dental care or prescription medication. To participate in the Medicaid program, States develop a *Medicaid State Plan* specifying which service options the State Medicaid program will offer.

One Medicaid service option states may elect is “home and community-based services” (HCBS). HCBS are long-term services and supports such as hands-on personal care, meals on wheels, or help with chores, shopping, or other tasks of daily living. These services, along with supportive case management, assist the elderly and people with disabilities avoid institutional care, and remain as independent as possible in their homes and communities.

Before recent Congressional amendments to the Social Security Act, a state could not elect HCBS through their State Plan, but instead applied to the Centers for Medicare and Medicaid Services (CMS) for a separate “1915(c) waiver.” The waiver requires the state to target HCBS only to those individuals who experience functional limitations so severe, that they would otherwise need to be cared for in a nursing home, hospital, or other institution. Alaska currently provides HCBS to approximately 4,000 individuals under four 1915(c) Medicaid waiver programs, Children with Complex Medical Conditions (CCMC), Adults with Physical and Developmental Disabilities (APDD), Alaskans Living Independently (ALI), and Individuals with Intellectual and Developmental Disabilities (IDD).

1915(i) State Plan HCBS Benefit – 1915(k) Community First Choice Option

Beginning with the Deficit Reduction Act of 2005 and continuing with the Affordable Care Act, Congress amended the Medicaid program to encourage states to take advantage of the benefits of HCBS. Section 1915(i) allows states to make HCBS available to people not eligible for institutional care, but still in need of service and supports to remain independent. Section 1915(k) creates a financial incentive for states to provide HCBS to people who would otherwise need institutional care, by offering a 6% increase, from 50% to 56%, in the “federal financial participation rate” (FFP). These options also offer administrative simplicity, as states may elect to provide HCBS under sections 1915(i) and 1915(k) not through a waiver, but through a Medicaid State Plan amendment.

State Plan HCBS benefits have several significant advantages over the 1915(c) HCBS waiver.

- 1915(i) allows the state to offer less intensive services and supports earlier and at lower costs, often keeping individuals from progressing to institutional care. In addition, individuals with significant disabilities that do not rise to the need for institutional care, such as Alzheimer’s disease or related dementias (ADRD), fetal alcohol spectrum disorder (FASD), or traumatic brain injury (TBI), may qualify for low-level, stabilizing HCBS.

- Unlike the current 1915(c) waivers, individuals who experience behavioral health disabilities are eligible for 1915(i) State Plan benefits. Provided currently with 100% state general funds via mental health grants, 1915(i) HCBS benefits provide needed access to services, while allowing the state to refinance them with 50% FFP.
- 1915(i) HCBS can also target adults leaving the corrections system and youth transitioning from the juvenile justice system. Access to health and behavioral health care has been shown to reduce recidivism in these populations, improving personal outcomes and saving the state money.
- In addition to the 56% FMAP, 1915(k) HCBS allow the recipient to purchase goods and services in lieu of personal care, such as a microwave oven, personal safety alert device or other assistive technology.

These reforms require involvement of stakeholders in the design and implementation of 1915(i) State Plan HCBS Benefits, and 1915(k) Community First Choice Option. CMS regulations require a consumer “Development and Implementation Council” to guide creation and implementation, with the majority of members seniors, people experiencing disabilities, and their representatives.

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Comparison of Medicaid 1915(c) Waiver, 1915(i), and 1915(k) State Plan Amendments

Adapted from: Comparative Analysis of Medicaid HCBS (1915 & 1115) Waivers and State Plan Amendments.
Prepared by Cooper, Flanagan, Crisp. January 2014.

| Features | §1915(c) Home and Community- Based Services Waiver | §1915(i) SPA State Plan Home and Community Based Services | §1915(k) SPA Community First Choice Option |
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| Authority Type | Waiver - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html | State plan option - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html | State plan option - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Community-First-Choice-1915-k.html |
| Effective Date | 1981 | Original: January 1, 2007 Revised: October 1, 2010 NPRM issued: May 3, 2012 | Original: October 1, 2011 Final Rule: May 7, 2012 |
| Purpose | Provides Home and Community-Based (HCBS) Services to individuals meeting income, resource, and medical (and associated) criteria who otherwise would be eligible to reside in an institution. | Provides HCBS to individuals who require less than institutional level of care and who would therefore not be eligible for HCBS under 1915(c). May also provide services to individuals who meet the institutional level of care. | Provides a new State plan option to provide consumer controlled home and community-based attendant services and supports. Provides a 6% FMAP increase for this option. |
| Requirements That May Be Waived | <ul style="list-style-type: none"> • Statewideness. • Comparability. • Community income rules for medically needy population. | <ul style="list-style-type: none"> • Comparability. • Community income rules for medically needy population. | Community income rules for medically needy population. |
| Application Process | Application submitted electronically via §1915(c) HCBS waiver application. Application and instructions found at: www.hcbswaivers.net | State plan amendment submitted on pre-print. Draft preprint can be obtained from CMS Regional Offices. | State plan amendment submitted on pre-print. Preprint can be obtained from CMS Regional Offices. |

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| Approval Duration | Initial application: 3 years. Renewal: 5 years. | One-time approval. Changes must be submitted to CMS and approved. If using targeting option, renewal every 5 years. | One-time approval. Changes must be submitted to CMS and approved. |
| Reporting | Annual reports. | Annual reports. | Annual reports on expenditures and utilization and quality measures. |
| Administration & Operation | Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding. | Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding. | Administered by the Single State Medicaid Agency (SSMA). |
| Provider Agreements | Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity. | Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity. | Required between providers and the SSMA. |
| Medicaid Eligibility | May use institutional income and resource rules for the medically needy (institutional deeming). May include the special income group of individuals with income up to 300% of SSI. | All individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. May include special income group of individuals with income up to 300% SSI. Individuals must be eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program. | Individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the FPL may use the institutional deeming rules. |

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| Other Eligibility Criteria | Must meet institutional level of care. | For the 300% of SSI income group, must be eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program. | Individuals must meet institutional level of care. May include the special income group and receiving at least one §1915(c) HCBS waiver service per month. |
| Public Input | CMS encourages States to obtain public input into the development of the waiver. While States are not required to obtain public input other than through the state Medicaid Advisory Committee, soliciting the views of affected parties is a positive practice. | Proposed regulation is silent. | Must create a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives. State must consult and collaborate with the Council when developing and implementing a State Plan amendment to provide HCBS attendant services. |
| Target Groups | <ul style="list-style-type: none"> • Aged or disabled. • Intellectually disabled or developmentally disabled. • Mentally ill (ages 22-64). • Any subgroup of the above. | May define and limit the target group(s) served. | No targeting. Services must be provided on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life. |

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| Other Unique Requirements | <p>None.</p> <p>Cannot cover: Room & board costs except for allowable transition services.</p> <p>Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.</p> | <p>Multiple State plan amendments covering different target groups permitted.</p> <p>Cannot cover: Room & board costs except for allowable transition services.</p> <p>Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.</p> | <p>MOE requirement for 1st fiscal year for services provided under §1115, §1905(a), and §1915, of the Act.</p> <p>Must establish & consult with a Development & Implementation Council with majority representation from consumers.</p> <p>Cannot cover: Certain assistive devices & assistive technology services; medical supplies & equipment, home modifications.</p> <p>Room & board costs except for allowable transition services.</p> <p>Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.</p> <p>Increased FMAP §1915(k)(2) of the Act provides that States offering this option to eligible individuals during a fiscal year quarter occurring on or after October 1, 2011 will be eligible for a 6 percentage point increase in the Federal medical assistance percentage (FMAP).</p> |

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| Limits on Numbers Served | Allowed. | Not allowed. | Not allowed. |
| Waiting Lists | Allowed. | Not allowed. | Not allowed. |
| Combining Service Populations | Combining service populations is limited to: 1) Aged/Disabled. 2) Intellectually Disabled or Developmentally Disabled. 3) Mentally Ill. 4) Any subgroup of the above. | States may combine service populations. | States may combine service populations. |
| Caps on Individual Resource Allocations or Budgets | Allowed. | May determine process for setting individual budgets for participant-directed services. | May determine process for setting individual budgets for participant-directed services. |
| Allowable Services | Statutory Services: <ul style="list-style-type: none"> • Case management services. • Homemaker/home health aide services & personal care services. • Adult day health services. • Habilitation services. • Respite care. • “Other services requested by State as Secretary may approve.” • Day treatment or other partial hospitalization services. • Psychosocial rehabilitation services. • Clinic services. • For individuals with | See §1915(c) services. Includes both §1915(c) statutory services and “other” category of services. Settings where individuals live must comport with community character guidance. | MUST COVER: <ul style="list-style-type: none"> • Assistance w/ ADLs, IADLs, & health related tasks. • Acquisition, maintenance & enhancement of skills necessary for individual to accomplish ADLs, IADLs, & health-related tasks. • Back-up systems or mechanisms to ensure continuity of services & supports. • Voluntary training on how to select, manage and dismiss staff. MAY COVER <ul style="list-style-type: none"> • Fiscal Management Services • Transition costs such as rent and utility |

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| Allowable Services (cont'd) | <p>chronic mental illness.</p> <p>Settings where individuals live must comport with community character guidance.</p> | | <p>deposits, 1st month's rental and utilities, bedding, basic, kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a NF, institution for mental diseases, or ICF-ID to a home & community-based setting where individual resides.</p> <ul style="list-style-type: none"> Expenditures relating to a need identified in an individual's person-centered plan that increases his/her independence or substitutes for human assistance to the extent the expenditures would otherwise be made for the human assistance. <p>Settings where individuals live must comport with community character guidance.</p> |
| Provider Qualifications | Determined by state, subject to CMS approval. | Determined by state, subject to CMS approval. | Determined by state, subject to CMS approval. |
| Participant-directed Services | Allowed. | Allowed. | Required. |
| Hiring of Legally Responsible Individuals | Allowed at the State's discretion. | Allowed at the State's discretion. | Allowed at the State's discretion. |
| Cash Payments to Participants | Direct cash payments not permitted. | Direct cash payment not permitted. | Direct cash payments are permitted. |

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| Financial Management Services | Required if participant direction is offered. May be a waiver service, an administrative function, or performed directly by the SSMA. | Required if participant direction is offered. May be covered as a service, an administrative function, or performed directly by the SSMA. | Required depending on model of participant direction. May be covered as a service, an administrative function, or performed directly by the SSMA. |
| Employer Status for Participant Direction | Participant may be the employer of record under a Fiscal/Employer Agent model or the entity may be the employer of record under an Agency with Choice model. | Participant may be the employer of record under a Fiscal/Employer Agent model or the entity may be the employer of record under an Agency with Choice model. Financial management supports are required to function as employer of record when the individual elects to exercise supervisory responsibility without employment responsibility. | Agency Provider Model: Services & supports provided by entities under contract or provider agreement. Participant has a significant role in the selection and dismissal of providers. Entity may provide services directly through their employees or arrange for the provision of services under the direction of the individual receiving services. Self-Directed Model with Service Budget: Service plan and budget directed by the individual and based on functional needs assessment. FMS must be available (SSMA may perform). Direct cash or vouchers may also be used. Other Service Delivery Model: States may propose other models |
| Goods and Services | Permitted as a waiver service. | Permitted as a service. | Permitted as a service. |
| Direct Payment of Providers | Required (state has options to meet this requirement). | Required. | Required. |

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| Provider Payments | Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement. | Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement. | Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement. |
| Cost Requirements | <p>Must be cost-effective.</p> <p>Average annual cost per person served under §1915(c) cannot exceed average annual cost of institutional care for each target group served.</p> | None. Benefit limits may apply. | <p>None. Benefit limits may apply.</p> <p>For the first full fiscal year in which the State Plan amendment is implemented, a State must maintain, or exceed, the level of expenditures for services provided under §1115, §1905(a), and §1915, of the Act, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.</p> |
| Quality Management | Extensive quality management and quality improvement activities required per the HCBS Waiver Application, including how state will comply with all multiple waiver assurances and how state will conduct quality oversight, monitoring and discovery, remediation and improvement of issues relating to quality. | Pre-print requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement. | <p>Requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement.</p> <p>State must provide system of performance measures, outcome measures, and satisfaction measures that will be monitored and evaluated.</p> |

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| Interaction with State Plan Services, Waivers, & Amendments | <p>Participants have access to and must utilize state plan services before using identical extended state plan services under the waiver.</p> <p>Waiver services may not duplicate state plan services.</p> <p>Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously.</p> <p>May be combined with other waivers such as §1915(a) or (b).</p> | <p>Individuals may be eligible for and receive State plan services, §1915(c), §1915(i) and §1915(j) services simultaneously, so long as the service plan (plan of care) ensures duplication of services is not occurring.</p> <p>May be combined with other waivers such as §1915(a) or (b).</p> | <p>Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously.</p> <p>May be combined with other waivers such as §1915(a) or (b).</p> |