ARC 9705C

PUBLIC HEALTH DEPARTMENT[641]

Adopted and Filed

Rulemaking related to brain injury services program

The Department of Health and Human Services hereby rescinds Chapter 56, "Brain Injury Services Program," Iowa Administrative Code, and adopts a new Chapter 56 with the same title.

Legal Authority for Rulemaking

This rulemaking is adopted under the authority provided in Iowa Code section 135.22B.

State or Federal Law Implemented

This rulemaking implements, in whole or in part, Iowa Code section 135.22B.

Purpose and Summary

The purpose of the Brain Injury Services Program is to provide services, service funding, or other support for persons with a brain injury under one of the program components established pursuant to Iowa Code section 135.22B. The overall purpose of this chapter is to establish administrative rules in accordance with Iowa Code section 135.22B relative to the financial eligibility requirements for services under the waiver-eligible and cost-share components of the Brain Injury Services Program.

While the services described in this chapter are not funded, the resource facilitation and training components of the program, which are not the subject of this chapter, have been continuously funded since 2006.

The chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result, the Department updated definitions to refer to the appropriate Iowa Code section; eliminated redundant, outdated, and restrictive language; and added dates certain.

Public Comment and Changes to Rulemaking

Notice of Intended Action for this rulemaking was published in the Iowa Administrative Bulletin on September 3, 2025, as **ARC 9527C**. Public hearings were held on the following date:

- September 23, 2025

No one attended the public hearings. No public comments were received. No changes from the Notice have been made.

Adoption of Rulemaking

This rulemaking was adopted by the Department on October 16, 2025.

Fiscal Impact

This rulemaking has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rulemaking, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rulemaking would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441—Chapter 6.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rulemaking by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rulemaking at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rulemaking will become effective on January 1, 2026.

The following rulemaking action is adopted:

ITEM 1. Rescind 641—Chapter 56 and adopt the following **new** chapter in lieu thereof:

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

641—56.1(135) Definitions. For purposes of this chapter, the following definitions apply:

"Assessment" means the review of the member's current functioning with regard to the member's situation, needs, strengths, abilities, desires and goals.

"Brain injury services waiver" means the same as defined in Iowa Code section 135.22B.

"Cost share" means the portion an individual is responsible to pay for services received by the individual.

"Countable income," when determining initial and ongoing eligibility for the brain injury services program, means all earned and unearned income unless specifically exempted in 441—subrule 86.2(2).

"Family size," for purposes of establishing initial and ongoing eligibility under the brain injury services program, means all persons living together who are children and who are parents of those children as defined in 441—subrule 86.2(3).

"Member" means an individual who has applied for and been found eligible to participate in the waiver-eligible component or the cost-share component of the brain injury services program.

"Program" means the department's brain injury services program.

641—56.2(135) Waiver-eligible component. Persons eligible for the brain injury services waiver and on the waiting list for the waiver are eligible for the waiver-eligible component. The program may provide funding for the nonfederal share of the cost of services if the appropriation for the medical assistance program does not have sufficient funding designated to do so.

56.2(1) Provision of funding under this component is not an entitlement and is subject to funding availability.

56.2(2) A person who receives support under the waiver-eligible component of the program is not eligible to receive support under the cost-share component of the program.

641—56.3(135) Cost-share component. Persons determined ineligible for the brain injury services waiver due to fiscal or functional criteria or persons who are eligible for the waiver but for whom funding was not authorized or available to provide waiver eligibility are eligible for the cost-share component of the program.

56.3(1) An individual must meet all of the following requirements:

a. The individual is aged one month through 64 years.

b. The individual has a brain injury as defined in Iowa Code section 135.22.

c. The individual is a resident of Iowa and either a United States citizen or a qualified alien as defined in 8 U.S.C. Section 1641 as amended to August 1, 2025.

d. The individual meets the cost-share component's financial eligibility requirements and is willing to pay a cost share for the cost-share component.

56.3(2) Financial eligibility and cost share. The department will use countable income to determine initial and ongoing eligibility for the program. Cost share will be as follows:

a. Individuals who are at 300 percent or below the federal poverty level for a family of the same size will not be assessed a cost share.

b. Individuals whose countable income is between 301 percent and 350 percent of the federal poverty level for a family of the same size will be assessed a 10 percent cost share for services that will be payable to the service provider.

c. Individuals whose countable income is between 351 percent and 400 percent of the federal poverty level for a family of the same size will be assessed a 20 percent cost share for services that will be payable to the service provider.

d. Individuals whose countable income is above 400 percent of the federal poverty level for a family of the same size will be assessed a 30 percent cost share for services that will be payable to the service provider.

56.3(3) The cost-share component must be the source of last resort for payment; the program will not pay for services when the provision of those services is mandated by law or administrative rule to be the responsibility of another governmental unit, private agency or program. Brain injury cost-share services are not available to an individual who receives services or funding under any type of medical assistance home- and community-based services waiver.

641—56.4(135) Application process.

56.4(1) The department will provide the application materials, including the waiver application and any denial letter, financial assessment, and functional assessment regarding the person in an agreed-upon format.

56.4(2) The department will determine eligibility within 45 days of receipt of complete application materials.

a. After determining if the applicant's service needs fit within the scope of the program, the department will inform the discharge planner or case manager on behalf of the applicant or the applicant's legal representative of the applicant's eligibility.

b. The case manager will establish an interdisciplinary team for each member and, with the team, identify the member's plan based on the member's needs and desires as well as the availability and appropriateness of services. The case manager will notify the department of the service plan.

c. The date of eligibility for applicants deemed eligible for the cost-share component will be the date when both the service eligibility and financial eligibility assessments have been completed.

d. The department will notify the applicant or the applicant's legal representative within seven days of the date eligibility determination is completed.

56.4(3) After determining an applicant's eligibility, if no payment slot is available, the program will enter the applicant on a waiting list according to the following:

a. The date a completed application is date-stamped in a county office of the department. If more than one application is received on the same date, applicants will be entered on the waiting list on the basis of the applicant's month of birth, with January designated as month one.

b. As slots become available, applicants will be selected from the waiting list based on their order on the waiting list to maintain the number of persons approved for participation in the program.

56.4(4) The member or the member's legal representative shall complete and sign a Brain Injury Functional Assessment form indicating the member's choice of caregiver.

56.4(5) The member's case manager will initiate development of the consumer's service plan and commencement of services. All service plans must be approved by the program.

56.4(6) The department will not pay the cost of services provided to a member prior to approval of eligibility.

56.4(7) The program will make the final determination as to whether program funding will be authorized under the cost-share component.

641—56.5(135) Service providers and reimbursement.

56.5(1) A service provider must either be certified to provide services under the brain injury services waiver or have a contract with a county to provide services and apply to become certified to provide services under the brain injury services waiver within 90 days of the date that services commence.

56.5(2) The reimbursement rate payable for the cost of a service provided under the cost-share component is the rate payable under the medical assistance program. However, if the service provider does not have a medical assistance program reimbursement rate, the rate will be the amount payable under the county contract.

56.5(3) All service providers must contract with the department and will be paid retroactively to the date of service eligibility.

56.5(4) Service providers will be responsible for billing and collection of any cost share from an individual as determined by the department.

641—56.6(135) Available services/service plan.

56.6(1) Services available will be consistent with the services offered through the Medicaid home- and community-based services waiver.

56.6(2) Service plans must reflect use of all services, including non-cost-shared services, to ensure that no duplication of services occurs.

56.6(3) All service plans must be submitted, either electronically or in hard-copy format, to the program for approval prior to implementation.

56.6(4) Any change to the service plan must be approved by the program.

641—56.7(135) Redetermination.

56.7(1) The department will annually conduct a complete financial redetermination of continuing eligibility for the program after consultation with the case manager and the interdisciplinary team.

56.7(2) The department will also conduct a redetermination of continuing eligibility when a change in financial or functional circumstances occurs that affects eligibility.

641—56.8(135) Appeal rights. Any individual denied funding under either the waiver-eligible or the cost-share component of the program may appeal pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code section 135.22B.

[Filed 10/16/25, effective 1/1/26]
[Published 11/12/25]
EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/12/25.