Subject: **Utilization Management**	Procedure: **Authorizations for Community Living Supports (CLS) and Overnight Health and Safety Supports (OHSS)**	
Last Updated: **3/19/2026**	Owner: **Managed Care Operations**	Pages: **6**

I. PURPOSE

To provide procedural and operational guidance to directly operated and contract providers on the documentation requirements for authorizations of community living supports and overnight health and safety.

II. DEFINITIONS

A. Community Living Supports (CLS):
Medicaid funded supports and services used to increase or maintain personal self-sufficiency, facilitating a person's achievement of their goals of community inclusion and participation, independence, or productivity. CLS provides training and/or teaching to the person served by assisting, prompting, guiding, and/or training with activities such as money management, meal preparation, routine household care, activities of daily living, shopping, and community inclusion. To be eligible for CLS, a person must be on the Healthy Michigan Plan (HMP) or one of the following Medicaid waiver programs: 1915(i) State Plan Amendment (iSPA), Children with Serious Emotional Disturbances Waiver (SED Waiver), Children's Waiver Program (CWP) or the Habilitation Supports (HSW).

B. Direct Assistance:
Hands-on physical care in which the staff performs a task for, or on behalf of, the person served.

C. Home Help:
Direct assistance in the person's own unlicensed home with meal preparation, eating and/or feeding, laundry, routine household care and maintenance, toileting, bathing, grooming, dressing, transferring, ambulation, medication management, and shopping.

D. Medical Necessity:
Determination that a specific service is medically (clinically) appropriate; necessary to meet needs; consistent with the person's diagnosis, symptomatology, and functional impairments; is the most cost-effective option in the least restrictive environment; and is consistent with clinical standards of care. The medical necessity of a service shall be documented in the individual plan of service (IPOS).

E. MI Coordinated Health (MICH):
MICH is a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) for Michigan residents. It is health plan coverage for those who qualify for both Medicare and Medicaid that offers a broad range of medical and behavioral health services. Members are provided a Care Coordinator through their assigned MICH health plan.

F. Overnight Health and Safety Supports (OHSS):
The need for an awake provider to be present to oversee and be ready to respond to a person's unscheduled health and safety needs if they occur during the overnight hours when they are typically asleep. To be eligible for OHSS, a person must be Medicaid eligible and on one of the following Medicaid waiver programs: Children with Serious Emotional Disturbances Waiver (SED Waiver), Children's Waiver Program (CWP) or the Habilitation Supports (HSW).

III. PROCEDURE

A. Community Living Supports are designed to provide a person served the opportunity to develop skills to attain or maintain a sufficient level of functioning to achieve their goals of community inclusion, independence, and/or productivity.

1. The person served must have active Medicaid entitlements and be on one of the eligible waiver programs as detailed in the definitions cited in Section II.

2. The person served must meet eligibility standards for MCCMH services as a person with a Serious Emotional Disturbance, a Severe Mental Illness, or a person with an Intellectual/Developmental Disability.

3. Through the person-centered planning process, it has been deemed medically necessary for the person served to receive CLS services to develop, increase, or maintain necessary skills.

4. CLS does not include direct assistance with personal care activities, including meal preparation, eating and/or feeding, laundry, routine household care and maintenance, toileting, bathing, grooming, dressing, transferring, ambulation, or medication management.

   a) CLS may be used for direct assistance with personal care activities only under the following circumstances:

      i. When a person served has applied for the Michigan Department of Health and Human Services (MDHHS) Home Help or Expanded Home Help and is awaiting a determination; or

ii. While a person served awaits the decision from a Fair Hearing of the appeal of an MDHHS decision regarding Home Help or Expanded Home Help.

b) CLS may be used for direct assistance with personal care activities on an ongoing basis for HSW recipients when their needs exceed the amount of approved MDHHS Home Help or Expanded Home Help.

B. Overnight services may be explored when there is a documented need for an awake provider to supervise the health and welfare of a person served during typical sleeping hours to maintain living arrangements in the most integrated community setting appropriate for their needs.

1. Overnight Health and Safety Supports (OHSS) are available to SEDW, CWP, and HSW recipients only. Non-Waiver recipients can utilize H2015 UJ for CLS during sleeping hours.

2. There must be documentation of behaviors or actions that require staff to provide assistance with incidental care activities during sleeping hours that cannot be pre-planned or scheduled.

3. This service is not available when the need is caused by a medical condition and the form of supervision is medical in nature or in anticipation of a medical emergency.

4. The primary case holder must evaluate and rule out that there are less intrusive and more cost-effective interventions that preserve health and safety and allow a person to remain in the most integrated community living setting prior to seeking authorization for OHSS or CLS for sleeping hours. This could include, but is not limited to, specialty supplies and equipment such as a Personal Emergency Response System (PERS) or other assistive technology.

5. This service is not intended to supplant services for the relief of the primary caregiver or legal guardian living in the same home or to replace a parent's obligations and parental rights of minor children living in a family home.

C. When a person served notifies their primary case holder of their interest in CLS and/or OHSS, the provider shall:

1. Identify if this is a treatment need for the person served, per the Michigan Medicaid Provider Manual, specific to the service and medical necessity.

2. The primary clinical provider discusses this service need as a part of the person-centered planning process.

3. CLS services may not supplant services otherwise available to the person served, including Home Help and Expanded Home Help.

4. Prior to seeking authorization for CLS, the primary case holder must assist the person served in requesting Home Help through MDHHS. For persons served enrolled in the MICH program, their Care Coordinator through their Health Plan is responsible for completing a Personal Care Assessment (PCA). The PCA is used in place of the Home Help assessment.

    a) Authorization requests for CLS can be initiated while awaiting the MDHHS or MICH determination.
        i. The initial authorization request can be submitted for up to sixty (60) calendar days.
        ii. Two additional authorization requests can be submitted for up to thirty (30) calendar days each if the person served continues to await the MDHHS or MICH determination.
        iii. It is expected that the MDHHS or MICH determination will be received and uploaded to the FOCUS EMR no more than one hundred and twenty (120) calendar days from the date of the Home Help application.
    b) The primary clinical provider must upload the MDHHS or MICH documentation in the Focus EMR. The determination must include a breakdown as to the amount of AHH authorized for each task area.
    c) The person-centered treatment plan must identify the amount of AHH authorized by MDHHS or the MICH and the task areas addressed.

D. The primary clinical provider ensures that this service is identified in the individual's person-centered treatment plan.

    1. The goal(s) must address the medical necessity of the service and include time-limited, measurable objectives and interventions that detail each area that the CLS staff will address with the person served.

    2. The goal(s) must identify the provider, and include the amount, scope, and duration of each service code.

    3. For someone on HSW the plan must document that, if not for this HSW service, the person served would require institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

4. The appropriate service codes are:

    a) H2015 XX: Community Living Supports

    b) H2015 UJ: Community Living Supports utilized during the individual's usual sleep hours for non-waiver recipients

    c) T2027: Overnight Health and Safety Supports for SEDW, CWP, and HSW only

E. The primary case holder assists the person served in identifying a provider for this service.

    1. A list of all CLS and/or OHSS providers can be found in the MCCMH Provider Directory.

    2. Persons served can hire family members or other natural supports to provide CLS and/or OHSS through the Self-Determination process.

        a) CLS and/or OHSS may not be provided by the parent of a minor, spouse of the person served, or legal guardian of the person served.

C. The primary clinical provider submits a prior authorization request to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). Authorization requests can be submitted up to sixty (60) calendar days, and no less than fourteen (14) calendar days, prior to the effective date of the authorization.

D. MCO has seven (7) calendar days to make a medical necessity determination on these requests.

    1. When it is determined that the person meets medical necessity criteria for the authorization of CLS and/or OHSS, the authorization is approved in the Focus EMR, and an electronic notification is sent to the primary clinical provider.

    2. When it is determined that the person does not meet the medical necessity criteria for all or part of the authorization of CLS and/or OHSS, the authorization is denied in the Focus EMR, and an electronic notification is sent to the primary clinical provider. MCO sends a Notice of Adverse Benefit Determination to the person served and/or their legal guardian.

IV. REFERENCES

MDHHS-Pub-1733: Home Help Program Client Handbook

V. RELATED POLICIES

A. MCCMH MCO Policy 4-020, "Medicaid and Non-Medicaid Notice of Adverse Benefit Determination"

B. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS

None

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	9/12/2024	Creation of Procedure	MCCMH MCO Division
2	12/3/2024	Implementation of Procedure	MCCMH MCO Division
3	3/19/2026	Revision of Procedure	MCCMH MCO Division