Pathways to Community Living/MFP Web Referral Process

- FAQ -

The Web Referral Form:

1. **How can I access the Illinois Department of Healthcare and Family Services' (HFS) web referral form?**
    a. You can access the web referral form through the MFP program website at www.mfp.illinois.gov. Click the "Referral" toolbar on the top left. You can also go directly to the web referral form through the following link - http://www2.illinois.gov/hfs/MFP/Pages/Referral.aspx
2. **Who can make a referral?**
    a. Anyone can make a referral. One reason the online referral process was implemented was to encourage self referrals and referrals from family members, friends and other stakeholders in addition to referrals received from community agencies and nursing facilities (NFs). Referral sources include the below sources among others:
        i. Community agency referrals
        ii. State agency referrals
        iii. Managed Care Organization (MCO) referrals
        iv. MDS 3.0 Section Q referrals (MDSQ) from Nursing Facilities
        v. Money Follows the Person (MFP) referrals
        vi. Colbert v. Quinn (Colbert) referrals
        vii. Ombudsmen referrals
        viii. Family referrals
        ix. Guardian referrals
        x. Self-referrals
3. **What should I do if I notice an issue with the web referral form?**
    a. You can email HFS.MFP@Illinois.gov to report issues with the web referral form. This includes problems submitting a referral or any other issue. If you are unable to find the correct facility in the drop down list you can also email this address.
4. **How do I know the referral went through?**
    a. Upon clicking the "Submit" button at the bottom of the referral form, you will be taken to a page that thanks you for the referral and confirms receipt of it. HFS is also working to implement an email confirmation that will provide persons who submit a referral a referral ID number upon submission if they include their email address. This will be implemented in the near future.
5. **How long does it take for a referral to be processed at HFS?**

a. Once a referral is entered into the web referral form, there is an hourly upload process that pushes the referral into the MFP web application for follow up. During this time, data validation checks also run to make sure the information on the referral matches information in the HFS data system. If no issues are found, the referral is routed directly to the agency responsible for follow-up. In this case, a referral will take no longer than 2 hours to reach the agency responsible for follow up. If data issues are found (e.g. no recipient found) HFS staff manually triage the referral. Finally, if the referral is for someone age 60 or over, an ANE check must be completed prior to releasing the referral (see #6 below).

6. **Are Adult Protective Services' Abuse, Neglect, and Exploitation (ANE) checks completed prior to a referral being distributed to the field?**
    a. Yes, HFS and the Illinois Department on Aging (IDoA) collaborate to complete ANE checks for individuals 60 years of age and older prior to distribution of web referrals. This information is shared with the local contact agency through the MFP web application.
7. **Doe the referral include Managed Care Organization (MCO) enrollment information?**
    a. Yes, referral data is validated against MCO enrollment data to determine if a person is currently enrolled with an MCO. If so, that information is added to the referral in the MFP web application to inform the Local Contact Agency.
8. **What is MDS Section Q?**
    a. Section Q is part of the Minimum Data Set (MDS) 3.0 assessment process NFs are required to administer to residents by the Federal Centers for Medicare and Medicaid Services (federal CMS).
9. **Does an LCA need to complete a Case Contact Form (A) in the MFP web application for all referrals?**
    a. Yes, a Case Contact Form (A) will need to be completed for all web referrals regardless of the outcome. This "closes the loop" and documents the referral was followed up on. This policy does not change the expectation that all MFP contacts and enrollments must be made face to face if the person remains in the nursing facility.
10. **Can I make a referral for someone who has already been referred through the MFP web referral form?**
    a. Yes, a person can be referral to the MFP program multiple times. If an existing case exists in the MFP web application for an individual, the transition coordinator assigned to that case will receive an activity notice through the application that notifies them that the person has been re-referred and to follow up accordingly.
11. **What does an LCA do if there is a change in the point of contact for my agency to receive referrals?**
    b. You should notify your state agency MFP lead and HFS as soon as possible via email. HFS MFP staff may be contacted via the "contact us" link on the MFP website at www.mfp.illinois.gov. HFS maintains an updated LCA list to determine the appropriate agency to receive program referrals based on the information contained on the MFP web application referral form.

12. **How will the LCA receive the referral?**
    c. Referrals are electronically distributed through the MFP web based case management application. If you have questions regarding the application please contact your state agency MFP lead or HFS via the "contact us" link on the MFP website at www.mfp.illinois.gov.
13. **What is the expectation for follow up on the referral once it is received by an LCA?**
    d. The expectation for follow-up is ten business days after referral is received from HFS. However, the ten business days does not start until the LCA actually receives the referral in the MFP web application. The time it takes HFS to process the referral does not count toward the ten days the LCA has to follow up.
14. **Who does an LCA notify if a referral was incorrectly received?**
    e. If an LCA receives a referral that is for a different geographic area or is for a population that the LCA does not serve (example: the person has a mental illness and the LCA serves the Aging or disabled population) an LCA may send that referral back to HFS for triage via the MFP web application itself. The LCA should not forward the referral to a different agency directly. Communication and collaboration between LCA agencies is encouraged, but the state is required to track MDSQ and web referral and report to federal CMS.
15. **Can an LCA follow up on a referral received directly from any source or does the referral have to be submitted via the online system?**
    f. All referrals need to be processed via the online referral system to be processed into the MFP web application. If asked, LCAs should instruct individuals to make a referral through the online system. An LCA can also assist a person to self refer through the website if internet access is available.
16. **Is there a different process for Colbert, MFP and MDSQ referrals?**
    g. The process for entering a referral is the same for all of these referral types. The only difference is where the referral will be sent to by HFS. Referrals for individuals residing in Cook County NFs are sent by HFS to Aetna and IlliniCare for follow up as a result of the Colbert implementation process. Across the rest of the state, MDSQ and MFP referrals are directed by HFS to the local Care Coordination Unit (CCU), Center for Independent Living (CIL), DDD Bureau of Transition Services, or local Mental Health Center based on the geographic location and the information contained on the referral form.

Referrals from Nursing Facility (NF) Staff – These questions are included to inform LCA staff in the case of questions from NF staff regarding the web referral process:

17. **Do all NF residents with an active discharge plan have to be referred through the web referral form**
    h. No, the NF does not have to refer all of its planned discharges (those with an active discharge plan in place) through the web referral form. The MDSQ items and skip patterns are designed to target only those individuals needing information about

available community services and supports and the extra collaborative efforts of LCAs to facilitate a successful transition to the community.

18. Does Medicare or Medicaid status affect referral requirements when a discharge is planned?

i. If the individual is not Medicaid eligible, then this situation would be a routinely planned discharge from a NF to a community-based residential setting. No referral to an LCA is required because the NF should already have a complete discharge plan in place and additional community resources, services and/or supports are not needed. Referrals to HFS or the LCA may be necessary in order for Medicaid to pay for the support services in the new setting. If the resident is making a routine-discharge move, (i.e: not triggered by a MDS Q item) and is paying for the services privately, then a referral to the LCA is not required.

19. If a previous referral has been determined to not be feasible to return to the community, does a subsequent referral require follow up?

j. The referral process is individualized and resident-driven, and the care planning team must interview residents and or their family, whenever possible, and determine their preferences. It should not be assumed that any particular resident could not be discharged. Federal CMS instructions are clear about the need to protect the individual's right to self-determination. However, there is an existing skip pattern in MDSQ that can be used to avoid inappropriate repetition. For example, item Q0400B asks, "what determination was made by the resident and the care planning team regarding discharge to the community?" If the resident (or family, or significant other, or guardian or legally authorized representative) and the care planning team had previously determined that discharge to the community is not feasible, and then the remaining items in MDS Q are not asked.

20. Does a web referral need to be made for someone who is diagnosed with dementia, requires 24/7 care and may or may not have an informal support system?

k. The Resident Assessment Instrument manual indicates that the NF interdisciplinary team should not assume that any particular resident is unable to be discharged. The NF should fully explore the resident's preferences and possible home and community based services/options available to the resident. If the NF interdisciplinary team determines that a resident with dementia cannot understand or answer the questions realistically, requires 24/7 care and does not have an informal support system, a determination of discharge to community determined to be not feasible can be made.

21. Does a web referral need to be made for short term stays or those with a set discharge date and discharge plan already in place?

a. The intent of the active discharge plan item on the MDSQ assessment is to determine that there is a discharge plan in place, which does not require that the resident be asked the return to community question by NF staff. Federal CMS realizes that particularly for newly admitted Medicare residents, there may be a targeted discharge date and discharge plan for follow-up medical, home health, and/or durable medical equipment services already in place, (i.e; the resident has a home to return to which may include a family member as caregiver, a local home care agency and medical equipment

provider). Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a LCA to access them. These are examples of having an active discharge plan in place and reflect that the NF's ability to develop, coordinate, and implement a person–centered discharge plan and process without the need for a LCA. An active discharge plan does not mean that a resident is ready for immediate discharge since some resources such as long-term waiting lists for housing could take several months.

22. Does there have to be a HIPPA signature for the NF to refer an individual through the web referral form?

b. No, there does not have to be a HIPPA signature when the NF directly asks the resident if the NF can give their name to a LCA so that the LCA can contact the resident. This referral of the individual's name is covered because the resident has given permission. The NF should document in the care plan and/or resident progress notes that the resident has provided a verbal okay to make the referral, and keep current the NFs standard medical release form that is signed upon admission by the resident or designee.