HUMAN SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Lorelei Kellogg, Acting Medicaid Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 23-05
DATE: 11/7/2023

TO: MEDICAL ASSISTANCE DIVISION

FROM: LORELEI KELLOGG, ACTING MEDICAL ASSISTANCE DIVISION DIRECTOR

THROUGH: KATHY LEYBA, BUREAU CHIEF, QUALITY BUREAU

SUBJECT: STANDARDIZED HEALTH RISK ASSESSMENT (HRA)

GENERAL INFORMATION
This form is for use by MCOs when they perform an HRA.

FILING INSTRUCTIONS
Please make the following changes to the MAD forms manuals:

REPLACE MAD 754

Please address any questions concerning these guidelines to: Katherine.Leyba@state.nm.us or call (505) 795-3763.

Attachment: MR 23-05 STANDARDIZED HRA – MAD 754 FORM 09.26.23

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Health Risk Assessment (HRA)

CNA Required for Items in **BLUE**

Member's Name (First, Middle, Last)	Member's Medicaid ID	Date

Has Member Given Permission for Another Person to Complete this form?	Name of Person Completing/Assisting with the Completion of This Assessment and Their Relationship to Member (the HRA must be completed by the guardian for members under the age of 14)
☐Yes ☐No	

Member's Address	City	State	Zip

Home Phone	Cell Phone	Other Phone

Emergency Contact Name/Phone	Date of Birth

Assessment Method	Demographics Verified?
☐Telephonic ☐In-person ☐Other (describe):	☐Yes ☐No

Assessment Type

☐Initial assessment ☐Change in health status

	Question	Response
1.	Do you have a language need other than English? Do you need translation services? Please describe:	☐Yes ☐No ☐Yes ☐No _____
2.	Do you have any special preferences we should be aware of?	☐Cultural preference ☐Hearing Impairment ☐Literacy ☐Religion/spiritual needs or preferences ☐Visual Impairment ☐None ☐Other (describe): _____
3.	What is your main health concern right now?	_____
4.	Do you have any current or past physical and/or behavioral health conditions or diagnoses?	☐Behavioral health diagnosis (CNA required) ☐Comorbid conditions (CNA required) describe: _____ ☐ICF/MR/DD (CNA required) ☐High risk pregnancy (CNA required) ☐Transplant patient (CNA required) ☐Medically Fragile Waiver Program (CNA required) ☐Medically Frail (CNA required) ☐TBI/ABI (CNA required) ☐Other acute or terminal disease (CNA required) describe: _____
5.	What sex were you assigned at birth, on your original birth certificate?	☐ Male ☐ Female ☐ X or intersex ☐ Decline/prefer not to answer.

6.	What is your current gender?	☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman ☐ Non-binary ☐ Other – please specify _____ ☐ Decline/prefer not to answer. *We ask this for reporting only. Your response will not have an effect on your benefits.*
7.	*For individuals over 10 years of age:* What is your Sexual Identity?	☐ Gay or lesbian ☐ Straight, that is not gay or lesbian ☐ Bisexual ☐ Other – please specify _____ ☐ Decline/prefer not to answer. *We ask this for reporting only. Your response will not have an effect on your benefits.*
8.	*For individuals over 10 years of age:* Are you pregnant? If yes, are you interested in being referred to the Home Visiting Program?	☐Yes ☐No ☐Yes ☐No
9.	*For individuals over 10 years of age:* Do you currently use tobacco and/or nicotine products? If yes, are you interested in receiving information on or participating in a tobacco cessation program? Do you have a history of using tobacco and/or nicotine products?	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
10.	(*Adult only question*) Compared to others your age, would you say your health is…..?	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
11.	Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	☐Yes ☐No (if yes, CNA required) _____
12.	Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for ER visit(s):	☐Yes ☐No ☐1☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more (if 2 or more, CNA required) _____ _____
13.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	☐Yes ☐No ☐1☐2☐3☐4☐5☐6 ☐7 ☐8 ☐9 ☐10 or more (if 2 or more, CNA required) ☐Yes ☐No (if yes, CNA required)
14.	How many medications are you currently taking?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more (if 6 or more, CNA required)
15.	Are you in any of the following situations?	☐Justice involved ☐CYFD custody

		☐Working with the Department of Health on a Plan of Care for the Comprehensive Addiction and Recovery Act (CARA) (if yes to any, CNA required)
16.	What is your current living situation?	☐ Homeless (CNA req.) ☐Living alone ☐Living in group home ☐Living in shelter (CNA req.) ☐Living with other family ☐Living with others unrelated ☐Living with spouse ☐Living in assisted living facility ☐Lives in out of state facility (CNA required) ☐Lives in out of home placement ☐Dependent child in out of home placement (CNA req.) ☐Living in a nursing facility ☐Other (describe):_____
17.	Do you need assistance with 2 or more of the following? Is your need for assistance being met today?	☐Yes ☐No (If yes, CNA required) ☐Dressing ☐Bathing/grooming ☐Eating ☐Meal acquisition/preparation ☐Transfer ☐Mobility ☐Toileting ☐Bowel/bladder ☐Daily medication ☐Other: _____ ☐Yes ☐No
18.	Do you need or are you interested in Long-Term Care services for these needs?	☐Yes ☐No (If yes, CNA required)
19.	An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advance directive in place? Could I send you more information?	☐Living will ☐Advance directive (for medical care) ☐Advance directive (for psychiatric care) ☐No living will or advance directive in place ☐Declined discussion ☐Requested further information

20.	Guidelines for Assessor explanation of Care Coordination: • A care coordinator is your main point of contact for information about services covered by [MCO name]. • These services include medications, doctor's appointments, physical therapy, medical equipment, hospital visits, vision and dental services and transportation to medical appointments. • Your care coordinator can help you find out if you qualify for Community Benefits. These benefits might include someone coming to your home to help you prepare meals or make home repairs that you need to stay safe. • Your care coordinator will help you find extra care and services from providers or community programs that are not covered by [MCO name]. • Your care coordinator will work with you and those who care for you to create a care plan. A care plan can help you meet your health goals. • There are two types of Care Coordination – Level 2 and Level 3. Level 2 is for people who need assistance with some of their health needs. Level 3 is for people with higher needs. • Your care coordinator will visit you in-person to do a Comprehensive Needs Assessment, or CNA. • The CNA will help find out what services you can receive. • Your care coordinator will check in with you every month or every few months by telephone. • Your care coordinator will visit you in your home at least once a year.

	• You can ask for a higher level of Care Coordination at any time. • Native American Members have the right to request a Native American care coordinator.	
21.	Are you interested in receiving Care Coordination Services?	☐Yes ☐No (If yes, CNA required)
22.	*For the Assessor: Inform the Member about specific next steps, such as scheduling the CNA or transferring the Member to Member Services or ISD for assistance with any issues that were discussed during the HRA.*	