

Medicaid Health and Recovery Plans (HARPs)

Keep the Supports.

Fix the Systems.



2025

Access to
Recovery
(A2R)
Coalition
Report

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Background

Acknowledgements

Thanks to the van Ameringen Foundation for their generous support of the Access to Recovery (AzR) Coalition.

The AzR Coalition is composed of people who receive HARP benefits, their loved ones, HARP service providers, and legal advocates. AzR was founded and is supported by staff at the Urban Justice Center (UJC) Mental Health Project (MHP). Thank you each for your incredible work and willingness to share your input and experiences as members of AzR.

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Foreword

AzR was created to improve access to and utilization of HARP services. AzR is for New Yorkers who live with significant mental health concerns,¹ as well as their loved ones, families of choice, and allies. AzR works to ensure that HARP truly assists individuals seeking person-centered recovery through effective, functional, and accessible home and community-based services. AzR operates on the core principle that people trying to access HARP benefits and on-the-ground professionals, such as peer specialists and care coordinators, are best positioned to advise state authorities, such as the New York State Department of Health (DOH), and the New York State Office of Mental Health (OMH).

We prioritize the perspectives of directly impacted people, while seeking and embracing allied support. AzR primarily works with people living in the five boroughs of New York City (the Bronx, Brooklyn, Queens, Staten Island, and Manhattan). However, the systems we seek to improve are statewide, and we welcome people from all over the state to our virtual meetings and events.

On a micro-level, A2R is about making space for directly impacted people to define their individual paths to recovery. In other words, helping individuals access their own benefits. On a macro-level, A2R aims to build community power and change Medicaid systems, so that they work better for people navigating mental health recovery services in New York.

The purpose of this A2R report is to: (1) highlight common systemic issues and (2) share innovative and potentially life-changing recommendations to improve the HARP program. The report identifies a variety of systemic barriers that interfere with the ability to access HARP's community-oriented supports. Unfortunately, less than 4% of eligible people throughout New York receive even one of these additional supports.² A2R believes that these small numbers are the result of antiquated and bureaucratic systems, as well as a lack of real input from people with HARP.

At A Glance

Below is a summary of some key issues under HARP that AzR has identified, as well as some recommendations to fix these issues.

Eligibility

Issues

1. HARP wellness supports could be excellent preventative care but are restricted to people with mental wellness concerns who have been hospitalized or incarcerated
2. Some people with both Medicaid and Medicare are ineligible for the full array of HARP supports

Recommendations

1. Expand HARP wellness supports to the entire Medicaid population – eliminate the eligibility barrier and multi-step processes
2. Ensure people with both Medicaid and Medicare can receive the full array of HARP supports

Ineffective Communication

Issues

1. DOH has not developed a meaningful partnership with directly impacted individuals and advocates to improve HARP
2. People are unaware of enrollment
3. Accurate information about HARP is not widely available
4. People are unaware of possible supports
5. Insurance plans do not adequately educate HARP members
6. Language and guidance from DOH and the plans are either overly vague or overly technical
7. The role of the care coordinator is confusing

Recommendations

1. Develop real, ongoing partnerships with impacted people and advocates to identify and implement remedies
2. Invest in accurate and accessible trainings for both recipients and on-the-ground staff
3. Pay peer specialists as “HARP Ambassadors” to improve the HARP enrollment process
4. Develop peer-reviewed, accessible materials in multiple formats and languages (e.g., short educational videos, at-a-glance brochures, social media channels) to “walk” people through accessing HARP
5. Make materials easy to find and require plans to share them directly with HARP participants, their chosen families, and “on-the-ground” providers

Resolving Individual Issues is Challenging

Issues

1. Complaints and fair hearings are often inadequate tools
2. HARP participants fear retaliation for filing complaints or fair hearings
3. Current “watchdog” systems are not sufficient

Recommendations

1. Develop peer-reviewed, accessible materials explaining grievance and complaint processes and protections against retaliation
2. List organizations that can represent HARP members at fair hearings on fair hearings notices

Inadequate Supports and Services

Issues

1. Care coordinators and providers do not receive sufficient training
2. Quality of supports are inconsistent
3. Gaps in time between receiving supports is the norm, often due to staff turnover or shortages
4. The “housing assistance” available through HARP is minimal

Recommendations

1. Develop a strong quality control entity to ensure consistency in supports at all levels of the process
2. Require continuity of care
3. Provide regular equity and cultural competency trainings and supports for all parties engaging with HARP members, especially care coordinators and insurance plan member services representatives
4. Mandate paid continuing education for care coordinators
5. Set reasonable case number limits
6. Train care coordinators on available housing assistance
7. Prioritize stable, safe, affordable housing using a “housing first” model

What is HARP?

Health and Recovery Plan (HARP) is a specific type of New York State Medicaid managed care plan.³ HARP is funded by both the federal government and New York State. The federal government oversees the program and sets certain rules and regulations, while the State Department of Health (DOH) and local counties administer it.

HARP offers broader health-management options than traditional Medicaid. HARP is available to people with significant mental health concerns, who are eligible for Medicaid managed care, at least 21 years old, and otherwise meet the eligibility formula.⁴ HARP allows these individuals to receive additional mental wellness supports and services. Many people who qualify for HARP have chronic co-occurring health conditions. Some people with Medicaid HIV Special Needs Plans (HIV-SNPs) are also eligible for HARP mental wellness supports.⁵

HARP offers a range of support services, such as expanded mental health wellness, peer support, stress and crisis management techniques, advocacy skills and knowledge, frameworks to improve life satisfaction, care coordination, job training, transportation, and more.⁶

HARP allows individuals to determine their behavioral health services. For example, HARP services help people work with their family of choice to understand how to best support them in recovery. Other supports can help people go back to work or school. Peer support, one of the most utilized HARP services, allows people in recovery to work with peer specialists. These support services aim to build individual skills, tools, and connections, so that a person can safely stay in the community and avoid institutions like hospitals, nursing homes, jails, and prisons, which can be traumatizing. Many of these supports are designed to address traditionally ignored but crucial areas of wellness called “health related social needs.”⁷

Through programs like HARP, New York State now recognizes that recovery is complex and different for everyone. Working ideally, HARP allows people to receive individualized services based on their needs. Unfortunately, this person-centered approach to recovery is not reflected in how HARP is experienced.



Challenges in Accessing HARP: An Overview

The number of people accessing HARP benefits remains disappointingly low. New York does not cover HARP supports for most Medicaid recipients. While one in three New Yorkers are enrolled in Medicaid, less than 200,000, of the nearly 8 million New York Medicaid enrollees are HARP eligible.⁸ Medicaid recipients only qualify for HARP after meeting strictly defined criteria, such as spending more than 30 days in psychiatric inpatient care or having three or more inpatient admissions within a three-year period.⁹ Further, DOH pre-defines who can access HARP based on a formula that is most responsive to individuals who have already experienced crises and institutional exposure. There is no way to apply for Medicaid HARP; DOH determines eligibility based on service usage. Once eligible, recipients either enroll in a HARP or are auto enrolled. After HARP enrollment, recipients begin the process to get HARP supports and services.

Those who have HARP discover that there is a huge learning curve in understanding how to access benefits. There are multiple steps, agencies, advocates, and people involved. Many people do not even know that they have HARP. Further, the system is challenging to navigate and nearly impossible for participants to receive benefits without significant outside advocacy. Many participants who start the process never finish because of the time and effort involved.¹⁰ Unfortunately, HARP providers and insurance plan staff are frequently undertrained or misinformed about the most basic HARP supports and steps to get those supports. Likewise, providers and advocates lack accurate information and often unintentionally give misinformation about how to access HARP services or the type of services that are available.

As of February 1, 2022, HARP supports have been divided into two types: Community Oriented Recovery and Empowerment services (CORE), and Behavioral Health Home and Community Based Services (BH HCBS). There are different steps to access these two types of services.

CORE Services

- Empowerment Services - Peer Support
- Family Support and Training
- Psychosocial Rehabilitation
- Community Psychiatric Support & Treatment

BH HCBS

- Habilitation
- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation

The process to access CORE services is simpler than accessing BH HCBS. For example, accessing CORE benefits does not require a referral from a care coordinator, joining a health home, or going through an eligibility assessment. However, BH HCBS remains the pathway to access habilitation, educational support services, employment services, and non-medical transportation.

Issues

While HARP is a promising program that offers many important services to participants, less than 4% of eligible HARP participants receive extra services that can improve their lives.¹¹ Below highlights some major HARP issues, as identified by the A2R Coalition.

Eligibility

Missed Opportunity for Preventative Supports

Addressing the mental health crisis has become a priority for elected leaders. Unfortunately, in New York, these changes focus primarily on post-crisis points, such as increasing the number of inpatient beds available, improving admissions, and enhancing discharge planning.¹² While these improvements are needed, there is a noticeable lack of resources dedicated to preventive services. Centering evidence-based initiatives that address mental health needs before a crisis increases the potential to avoid post-crisis life events like hospital admissions and incarceration.

Medicaid HARP services act as preventative supports for those who qualify. A 2021 Health Services Research study concluded, “recipients who maintained at least two years of continuous enrollment [in HARP] showed significant reductions in hospitalizations and increases in access and utilization of outpatient health services.”¹³ The purpose of Medicaid HARP is to “provide the enrollee with specialized supports to remain in the community and assist with recovery.”¹⁴

Unfortunately, however, millions of New Yorkers are not able to benefit from HARP’s preventive services due to its eligibility restrictions. Instead, low- and no-income New Yorkers must suffer a severe life crisis before being allowed to access HARP’s potentially life changing supports and services.

Duals May Be Ineligible for Some Supports

When someone is eligible for both Medicaid and Medicare services, the person is said to be “dually eligible.” People who are dually eligible are often referred to by advocates as “duals.”

Becoming “a dual” for the first time can be a confusing and burdensome experience.¹⁵ Duals have a dizzying constellation of options to choose from and a host of processes and vocabulary to learn.¹⁶

For example, a dual can have multiple types of coverage at the same time.¹⁷ There is a specific list of health services available through each coverage type. Additionally, each coverage type may have separate member service lines, provider networks, geographical areas of coverage, application processes, service authorizations, and appeal procedures.

Some people can combine this array into an “integrated plan,” but this approach has pitfalls. Integrated plans are administered through Medicare Managed Care Organizations (MCOs), not Medicare Fee-for-Service (FFS).

Someone in Medicare FFS can use any Medicare provider, anywhere in the United States, while someone in a Medicare MCO is limited to a particular geographical area and provider network. Additionally, there are multiple MCOs that a person can choose. Each MCO has its own area and network, so going the integrated route requires advance research to make sure a person's needs are met by that specific MCO's area and networks.

In the past few years, steps have been taken to simplify the situation for duals generally and to build stronger continuity of care.¹⁸ In addition, covered mental health supports have improved for duals.¹⁹ For example, crisis intervention services, such as mobile crisis or residential crisis supports are now available to all New Yorkers, regardless of ability to pay.²⁰

Now, HARP enrollees who become duals are default enrolled into either a Medicaid Advantage Plus (MAP) or an Integrated Benefits (IB-Duals) plan.²¹ If a dual needs long-term supports and services, such as home care, then the person is enrolled into a MAP plan.²² If not, they are enrolled into an IB-Dual plan.²³

MAP enrollees (HARP duals with long-term needs) have access to some HARP services.²⁴ Unfortunately, MAPs do not cover all HARP services. They cover CORE services and crisis intervention, but not BH HCBS.²⁵

IB-Duals enrollees (HARP duals without long-term needs) have access to the full array of CORE and BH HCBS services. However, the Medicaid Managed Care 'model contract' has not yet been updated to include language that CORE is a covered benefit for IB-Duals with HARP.²⁶ Further, only some MCOs offering HARP plans also offer IB-Duals plans. As a result, some HARP duals will have to go through the stress of switching MCOs. Switching MCOs comes with the risk of losing current providers and facing gaps in services.

Because integrated plans are offered through MCOs, both MAPs and IB-Duals have their own provider networks for both Medicaid and Medicare covered services. As such, integrated plans may not be a workable option for some people.²⁷ For example, some HARP duals opt for FFS Medicare due to their personal, medical, and social circumstances, and in doing so lose both CORE and BH HCBS supports.

Ineffective Communication

No Meaningful Partnership with Directly Impacted Communities and Advocates

Unfortunately, despite temporary State efforts, such as the Regional Planning Consortia, HARP continues to operate largely without the voices of directly impacted people.²⁸ Without real, ongoing partnerships with people who can benefit from mental health recovery services and their chosen families supports, OMH and DOH may miss opportunities to identify and resolve key issues.

People Are Unaware of Enrollment

It is common for a HARP recipient to have been eligible or even enrolled into a HARP for months or even years without having any knowledge about it. DOH sends a notification letter to beneficiaries through New York Medicaid Choice (NYMC).²⁹ Both the communication method and the letter's content are lacking. Sending a letter to beneficiaries is not a guarantee that they will receive the information. Some people with mental health concerns have difficulty managing their mail due to their symptoms, the side effects of medications, and/or the everyday stressors of life. Some may not have a stable mailing address.

In addition, the letter is too technical and does not offer enough detail. The language is not accessible for basic reading levels. It also does not offer any practical information about what new services are available or how to get them. Beneficiaries are told to call NYMC, but its automated phone system is challenging to navigate, and the representatives have little information to share beyond what is in the letter already. NYMC may advise participants to call the insurance plan, which is often unhelpful, as insurance plan staff may offer contradictory or incomplete information.

Some HARP beneficiaries also get a phone call from a health home or care management agency intake worker. The caller may ask for identifying information, which is alarming for some. When asked, some HARP beneficiaries describe having a memory of someone calling, but they did not know the person who was calling or what the call was about, so they never called back. Many HARP beneficiaries also do not have a stable phone number.

Accurate Information Is Not Widely Available

There is a real loss of opportunity to introduce and explain HARP throughout the dozens of “doors” into mental wellness networks and systems in New York. In theory, a beneficiary should be able to learn about HARP from any Medicaid medical or service provider. However, in practice, most HARP recipients receive no information, misinformation, or contradictory information. For example, one HARP participant stated:

“It’s too hard to find out about Medicaid HARP. Even having had Medicaid for a few years, I just recently found out about it. I would change how it is delivered and how the information gets out. The benefits are great, people just need to know they have it. It can help people and once people get access, they do well with it. I’ve learned the most about HARP through AzR and the town halls.”

Insurance Plans Do Not Adequately Educate Members

Advocates and HARP participants report that conversations with representatives from managed care companies are unhelpful. Member services representatives at managed care companies are often completely unaware of HARP. Even representatives working the designated HARP line, at the plan, are often confused about HARP. HARP advocates have frequently experienced plan representatives attempting to transfer a HARP participant asking for connection to a “health home” (for people seeking a health home care coordinator) to the “home health care” department (for people seeking assistance with activities such as bathing, shopping, cleaning, or dressing).

People Are Unaware of Supports

State-produced brochures tend to be vague about the services and may be outdated.³⁰ The lack of educational materials leave many HARP participants unaware of the services available to them. While there is information on the OMH website, the website is not an accessible source for many HARP beneficiaries. The information on the OMH website tends to be geared towards program administrators who are familiar with technical language, leaving both HARP participants, care coordinators, and case managers with little understanding of what supports or services are available.

Language Is Not Accessible

The language of HARP is too technical and overly wordy, acronyms are not explained, and there is little visual representation for diverse kinds of learners and reading levels. The system does not consider all literacy levels, even in crucial steps towards getting services, such as completing the Health Home Patient Information Sharing Consent form. The process frequently stalls at this point, in part, because the form is dense and people explaining it are in a hurry to get through the paperwork. HARP participants are then forced to either admit they do not read at the level of the form, sign without understanding, or entirely give up on getting services.

Additionally, materials in languages other than English are rare. There are a few brochures in multiple languages, but more in-depth materials are usually in English. Resources are almost entirely directed at program directors and other high level HARP staff. Leaving many beneficiaries and on-the-ground staff confused.

Care Coordinator Role Is Confusing

Many HARP beneficiaries have more than one case manager contacting them, either from a supportive housing program or a mental health service provider. Many HARP beneficiaries’ express confusion about who exactly is responsible for which part of their Medicaid benefits, and they do not know which person to go to when seeking to resolve an issue.

Inadequate Supports and Services

Insufficient Training

HARP recipients widely report issues with quality supports and services, particularly at the care coordinator level. Care coordinators and providers have stated that the level of training provided is insufficient. Care coordinators are given caseloads prior to fully understanding the HARP process. They do not appear to have the support needed to learn the next steps from their agency employers, and they often must contact legal service agencies for assistance. One HARP recipient stated:

“I have noticed that the doctors and Technical Assistants are not always up to date on how to send forms, requests, follow up documents, tests, etc. to be able to deliver the supports necessary for the patients. There must be more training (and built-in refresher courses and team meetings), checks and balances for performances and proper documentation, and a higher level of communication overall between the doctor, staff, referral partners, and client.

I think if everyone (doctor, nurse/practitioners), Care Managers, Technical Assistants (triage staff), referral partners AND [emphasis added] the client were in one room, listening to how the HARP Plan works - it would work! Resulting in better health outcomes, costing the city/insurance companies less money and headache of systematic confusion and drain.”

Gaps In Supports

Due to high levels of staff turnover, HARP beneficiaries experience frequent and sudden losses in care. Beneficiaries are often not informed about the loss until an appointment is canceled. It can take months before services continue, leaving vulnerable people without the support that HARP is supposed to provide. When a new staff member is assigned to a beneficiary, a new relationship must begin again, leaving beneficiaries without stable support. One HARP participant stated:

“I’m on my third care coordinator in this program. In my opinion, the care coordination system has become a useless and extra hurdle for me to receive services. Too much paperwork and far less person-to-person interactions. Through all the different agencies I tried, I have been subject to re-stigmatization, no matter how much I have accomplished in my life to date both personally and professionally.”

Housing Assistance is Minimal

Some HARP brochures mention that participants can receive assistance with housing. However, in reality, HARP “housing assistance” is little more than a referral to another overburdened social services program or some help filling out an HRA 2010e Supportive Housing Application. A program that promotes health related social needs should value the impact housing has on mental wellness. A tremendous oversight in the HARP program is failing to address the ongoing crisis in lack of safe and affordable housing for people with mental health concerns.

Challenges Resolving Individual Issues

Participants Fear Retaliation

HARP beneficiaries report fear of retaliation, so they prefer not to “stir the pot” even when they are experiencing negative treatment or other unprofessional interactions with care coordinators or other providers. Many beneficiaries express a complete lack of faith that reporting a problem will not lead to worse treatment, losing services that were already difficult to obtain, or both.

Complaints and Fair Hearings are Inadequate

When issues arise, beneficiaries may file complaints and grievances with either the provider agency or with the relevant State Department. It can be confusing figuring out what contact information to use for a complaint or grievance. Further, filing complaints and grievances has no predictable outcome. Often an issue is resolved without either the beneficiary or advocate ever receiving any outreach or report as to what precisely happened. This ‘behind closed doors’ approach makes it difficult for both recipients and advocates to build Medicaid literacy and solve issues without leaning on complaint lines. Seemingly just as often, the staff responding to the complaint does not understand the issue and closes the request after taking an action that does not address the problem.

Medicaid beneficiaries may also file a fair hearing before an Administrative Law Judge (ALJ) with the Office of Temporary and Disability Assistance (OTDA), only after meeting other procedural barriers.³¹ These hurdles add extra delays for people seeking medical care. Further, a fair hearing can take many months to schedule.

Some ALJs seemingly do not understand Medicaid or fair hearing regulations, leading to decisions that do not fully contemplate entitlements. Of course, these decisions can be appealed. However, appeal processes are complex and can take years to complete. Unfortunately, this is time few have when dealing with a health matter. Many beneficiaries’ resort to actions such as switching plans or simply requesting the same authorization a second time - hoping for a different result. Others simply give up.

Thus, while both complaint lines and fair hearings allow for self-representation, an advocate is often needed to have a better chance of success.

“Watchdog” Systems Are Not Sufficient

While there is a HARP Ombuds program that ideally would operate as a system “watchdog” on behalf of the public, the program is limited.³²

The program was set up so that advocates at community-based organizations (CBOs) are the Ombuds program staff. Essentially, the State pays CBOs to staff the hotlines and conduct advocacy for members who reach out for assistance. Thus, CBOs have dedicated funding to assist Medicaid recipients who otherwise would not be able to afford legal assistance, which we support. However, the payment mechanism also creates a potential conflict of interest – CBOs paid by the system they monitor may not be as free to criticize that system.

Further, Ombuds staff can no longer represent Medicaid members at fair hearings. When the program was set up, free representation from an experienced advocate was the norm. The hotline was even required to be listed on denial notices from health plans. To be clear, Ombuds staff can and do provide excellent advocacy and advice to the public - often resolving issues without the need for a fair hearing. However, when needed, fair hearing representation is no longer a part of that advocacy.

Recommendations

AzR provides the following community-sourced recommendations to decision makers, such as staff at the Department of Health and the Office of Mental Health, as well as to advocates and directly impacted communities. While this is not an exhaustive list, it is our aim that these recommendations from HARP members and affiliated communities are useful and lead to better health care for Medicaid recipients.

Expand HARP to All Medicaid Recipients

Eliminating HARP and allowing direct enrollee access to CORE and BH HCBS services would be an investment in the health and safety of all New Yorkers. Eliminate the overly bureaucratic process, such as the post-crisis eligibility formula and multi-step approval processes. Keep health home care coordination, but as an optional source of information and support, rather than a step towards getting approved for other services. To improve the wellness of our population, CORE and BH HCBS supports, like therapy and psychiatry, also should be used as preventative methods available to all Medicaid recipients.

Ensure Duals Receive All Supports

All CORE, BH HCBS, and care coordination supports should be an option for all duals. Qualifying for Medicare does not end a person's need for mental wellness or recovery services. In fact, depression and other mental health concerns may be increasing among older adults. One study concluded, “[a]lthough the estimated prevalence of depression is increasing among older adults, there has not been a proportional increase in mental health treatment.”³³ These findings call for urgent expansion of treatment services and training of mental health professionals, with expertise in serving older adults. DOH must ensure Medicare eligibility does not put vulnerable populations into a position of having even less support.

Develop Meaningful Partnerships Directly with Impacted Communities and Advocates

Directly impacted people and communities offer unique, crucial, and timely insight into how the HARP systems and supports are functioning. DOH must develop and maintain meaningful partnerships with this population. DOH must value and respect HARP beneficiaries to make the program a success. AzR commends the OMH for beginning the process of meaningful community engagement through AzR's January 2022 CORE Town Hall trainings for HARP consumers.³⁴ This joint effort can serve as a foundation for more transparent and effective mental healthcare system for the members of our community who are often left behind.

Hire Peer Ambassadors to Improve Enrollment Process

Hiring peer specialists or other HARP “ambassadors” to introduce HARP to enrolled or eligible persons. Peers or HARP ambassadors can be a great resource and should be involved throughout the process. A peer specialist or advocate who has had experience with the system could explain how HARP has benefited their lives and make the process more human and relatable.

Invest In Training and Support

DOH must invest significantly in better training resources for both participants and on-the-ground staff, such as care coordinators and peer support specialists. DOH must design training resources in partnership with directly impacted people and staff. Involving both will better ensure the topics and method of delivery are useful and clear. AzR additionally recommends, prior to publishing materials, bringing in focus groups with no or low understanding of HARP to test whether guidance is accessible.

Develop Widely Accessible Materials

Materials must be developed with easily understandable step-by-step infographics or flowcharts that describe the HARP enrollment process and available supports. DOH should develop materials using “universal design” principles, describing rights or processes, in Medicaid HARP, in multiple accessible formats and languages.³⁵ Materials must define and describe acronyms. All technical language used must be explained. Sentences should be short. For example, stating that HARP offers Psychosocial Rehabilitation or Community Psychiatric Support and Treatment means little to the average person. DOH must explain what these services are in plain language for people of different reading levels. Further, DOH must make materials available in multiple formats, such as videos, songs, plays, or animated PowerPoints, which allows for different learning styles and language proficiencies. PowerPoints and webinars should have visuals and graphics illustrating the information, as well as closed captioning and American Sign Language interpretation. DOH should also develop materials appropriate for social media consumption.

DOH should post any HARP webinars or other materials on one central and navigation-friendly website. The website should include all webinars created about HARP, divided into sections such as, “For Providers”, “For Managed Care Organizations”, and “For People with a HARP plan.” DOH should develop a public-facing HARP-specific listserv that posts any new information about changes to HARP, so beneficiaries and providers can have the most up-to-date information. DOH should develop and distribute accessible written materials to providers such as social workers, psychiatrists, primary care physicians, etc.

Develop Strong Quality Control

A central, independently funded State HARP oversight department, with directly impacted people and advocates taking meaningful, paid roles should be established. While there is a small State Ombuds program, as well as internal quality control departments at many plans and providers, these solutions are not sufficient to address large systemic issues. An independent State oversight department is needed, rather than internal plan quality controls, as beneficiaries, providers, and plans have different interests.

Require Continuity of Care

DOH should require each health home, care management agency, and service provider to develop a continuity of care plan to ensure beneficiaries are informed of staff changes to help eliminate gaps in services. Paid “secret shoppers” might help in quality monitoring at insurance plans and care management agencies.

Implement Cultural Competency and Racial Equity Trainings and Supports

DOH must implement equity, diversity, inclusion, and cultural competency trainings for staff in health homes, care management agencies, and provider agencies. Beneficiaries should be supported in assisting their care coordinators and other staff with finding supports that work best for them. For example, some beneficiaries are disinterested in “medical model” approaches, such as psychiatric medication, but they could be engaged if offered activities such as meditation, dance, or acupuncture. Culturally appropriate wellness tools should be part of New York Medicaid.

Require Care Coordinators Receive Continuing Education and Reduce Caseloads

DOH should require care coordinators to maintain continuing education credits. This ongoing training can ensure care coordinators are aware of any changes and current policies, procedures, and requirements.

A 2022 review of care coordination interventions for high-utilizing patient populations found that “high caseloads pose challenges [and] contribute to staff burnout.”³⁶ “One study found that care coordination programs successfully reduced hospitalizations when they included frequent in-person contact with patients, at least once a month.”³⁷ Lower case limits would allow care coordinators the time to conduct successful in-person contact and contribute to reducing burnout.

Provide Accessible “Know Your Rights” Materials to Enrollees

At least annually, Medicaid enrollees should be provided peer-reviewed, accessible materials explaining grievance and complaint processes, including protections against retaliation. HARP enrollees should additionally be provided the same for each health home or provider they encounter. DOH should provide contact information for advocacy organizations that offer full fair hearing representation on Medicaid notices (in addition to the Ombuds program contact information).

Prioritize Stable, Safe, Affordable Housing

Securing and maintaining stable, affordable housing is a critical part of wellness. At a minimum, care coordinators should be able to connect HARP recipients with experts in securing stable and affordable housing, as well as competently assist with any application processes people would like to pursue. DOH should issue clear guidance for care coordinators on addressing participants’ housing needs. DOH should further invest in affordable, permanent housing for people living with mental health concerns, including those with substance use disorders. Such housing must fill the equity gaps that currently exist. For example, most supportive housing caters to singles and families with children. More help is needed for couples and those without children. A “Housing First” approach, already piloted by New York City, provides people with serious mental health concerns, who are experiencing homelessness, with housing and on-site supports without their first having to prove “readiness” for permanent housing or meet complicated eligibility requirements.³⁸ The “Housing First” model has been proven effective in reducing homelessness and improving quality of life for those given housing.

Endnotes

¹AzR prefers the phrase “people who live with significant mental health concerns” over phrases such as “mentally ill” or “mental health diagnoses.” The mental wellness community has expressed that those phrases are antiquated, dehumanizing, and stigmatizing. We include “substance use disorder” under the umbrella of “mental health concerns.” New York State uses the term “serious mental illness/substance use disorder (SMI/SUD)” in their materials, so quotations will be used when referring to these materials.

²NYS Behavioral Health (BH) Home and Community Based Services (BH HCBS) Dashboard Data, available at: https://omh.ny.gov/omhweb/bho/core_hcbs_access_dashboard.pdf (percentage calculated utilizing data published April 2025).

³To learn more about Medicaid 101 and HARP 101, watch this virtual training produced by Urban Justice Center Mental Health Project in coordination with NAMI-NYC, available at: <https://youtu.be/hqkXTsj7Gvo>

⁴See the New York Request for Qualifications or Behavioral Health Benefit Administration, State of New York Managed Care Organizations and Health and Recovery Plans. Section 1.8 Covered Populations and Eligibility Criteria, Part B, p. 17-18.

⁵HIV-SNP is a Medicaid health plan that covers all the same services as other Medicaid health plans, and additional specialty services important to people living with or at risk for HIV/AIDS. See <https://www.health.ny.gov/diseases/aids/general/resources/snps/>

⁶These services are currently called Behavioral Health Home & Community Based Services (BH-HCBS) and Community Oriented Recovery and Empowerment Services (CORE Services). Some people with HIV Special Needs Plans (HIV-SNPs) are also eligible to receive BH-HCBS and/or CORE services. For purposes of brevity and clarity, we will be using the term “HARP services” or “HARP supports” throughout this report

⁷Health-related social needs are social and economic needs that affect an individual’s ability to maintain their health and well-being. These include needs such as employment, affordable and stable housing, healthy food, personal safety, transportation, and affordable utilities. See <https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf>

⁸This is reflected in the NYS BH HCBS and CORE Dashboard data. According to the March 2024 Dashboard, in the past 12 months, only 12,075 of 189,352 HARP eligible New Yorkers received even one CORE or BH HCBS service. See https://omh.ny.gov/omhweb/bho/hcbs_access_dashboard.pdf (adding up both NYC and ROS numbers).

Endnotes

⁹See “Behavioral Health High-Risk Eligibility Criteria” available at: <https://omh.ny.gov/omhweb/bho/bh-high-risk-eligibility-criteria.pdf>

¹⁰See NYS Behavioral Health (BH) Home and Community Based Services (BH HCBS) Dashboard Data, available at: https://omh.ny.gov/omhweb/bho/hcbs_access_dashboard.pdf

¹¹See https://omh.ny.gov/omhweb/bho/core_hcbs_access_dashboard.pdf (As of April 2025 - 5,885 CORE/HB HCBS recipients divided by 182,659 HARP eligible).

¹²See <https://www.governor.ny.gov/programs/transforming-new-york-states-continuum-mental-health-care>, [https://www.nyc.gov/office-of-the-mayor/news/140-23/mayor-adams-ambitious-mental-health-agenda-focused-improving-family-child-mental#/o](https://www.nyc.gov/office-of-the-mayor/news/140-23/mayor-adams-ambitious-mental-health-agenda-focused-improving-family-child-mental#/)

¹³See: “Impact of the 1115 behavioral health Medicaid waiver on adult Medicaid beneficiaries in New York State” available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8313966/>

¹⁴See “Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation,” p.3, available at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/related_links/docs/bh_policy_guidance_10-1-15.pdf

¹⁵According to NYS DOH, “The healthcare coverage for duals is often fragmented and lacks coordination. Members frequently receive their Medicare benefits from one health plan or Medicare Fee-For-Service (FFS), while receiving their Medicaid benefits from a separate health plan or Medicaid FFS. Duals are one of the most complex populations and the bifurcation of the sources of their health benefits leads to inefficiencies, a lack of coordination and potentially diminished health outcomes.” New York State Dual Eligible Integrated Care Roadmap (March 2022), p.2 available at: https://www.health.ny.gov/health_care/medicaid/redesign/duals/docs/2022_roadmap.pdf

¹⁶Explaining the full array of duals options goes beyond the scope of this report, but for an overview, see “Dual Eligible New Yorkers,” available at: www.health.ny.gov/health_care/medicaid/redesign/duals/index.htm ; See Also “Coverage Options for People with Medicare and Medicaid in New York,” available at: <https://www.medicareinteractive.org/pdf/Coverage-options-for-duals-table-NY.pdf>

¹⁷For example, a dual could have these six different types of coverage at the same time: (1)Medicaid Fee-for-Service, (2)Medicaid Managed Long Term Care, (3)Medicare Part D, (4)Medicare Fee-for-Service, (5)Medicare Part A, and (6)Medicare Part B.

Endnotes

¹⁸See

https://www.health.ny.gov/health_care/medicaid/redesign/duals/docs/2022_roadmap.pdf

¹⁹Until recently, becoming a dual automatically removed enrollees out of HARP and cut off their access to HARP services and supports. See:

https://www.health.ny.gov/health_care/medicaid/redesign/duals/docs/2022_roadmap.pdf

²⁰For details, see: <https://omh.ny.gov/omhweb/bho/crisis-intervention.html> ; See also: State Plan Amendment Updates for Crisis Residence Reimbursement Standards, available at: <https://omh.ny.gov/omhweb/bho/docs/state-plan-amendment-updates-for-crisis-residence-reimbursement-standards.pdf>

²¹Duals may opt out of these plans. See

https://www.health.ny.gov/health_care/medicaid/redesign/duals/docs/2022_roadmap.pdf

²²Id.

²³Id.

²⁴See <https://omh.ny.gov/omhweb/bho/map-bh-billing-and-coding-manual.pdf>

²⁵Id.

²⁶See

https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf (last updated 03/01/2024 as of 06/15/2024)

²⁷See <https://omh.ny.gov/omhweb/bho/map-bh-billing-and-coding-manual.pdf>

²⁸Regional Planning Consortia, or RPCs, have been “sunset” as the funding for them has run out. See <http://www.clmhd.org/rpc/>

²⁹See “Notices to Consumers Eligible for Health and Recovery Plan (HARP) Enrollment,” available at: omh.ny.gov/omhweb/bho/harp-eligibility.html

³⁰See, for example, “Adult BH HCBS Brochure,” available at:

<https://omh.ny.gov/omhweb/bho/hcbs.html>

³¹For more information about Fair Hearings, see:

<http://health.wnyc.com/health/entry/237/>

³²For more information about the Ombudsprogram, see:

<https://nyscouncil.org/champ/> and see:

<https://www.cssny.org/programs/entry/champ>

Endnotes

³³Yang, Kevin. Trends in Major Depressive Episodes and Mental Health Treatment among Older Adults in the United States, 2010–2019. *Journal of Affective Disorder*, 1 Dec. 2022, www.sciencedirect.com/science/article/abs/pii/S0165032722010023?via%3Dihub

³⁴“Introducing CORE: Community Oriented Recovery and Empowerment (January 2022),” available at: youtube.com/playlist?list=PLxQ7h6JEjCdZMPR7ssrotCYwLbrf3KCTo

³⁵United Nations. “Article 2 - Definitions | United Nations Enable.” Un.org, 2019, www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-2-definitions.html

³⁶See “Systemic Review of Care Coordination Intervention Linking Health and Social Services for High-Utilizing Patient Populations” (2022) available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8861924/#B33>

³⁷Id.

³⁸See “The Case for Housing First,” available at: <https://nlihc.org/sites/default/files/Housing-First-Research.pdf>