Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258 On the Internet: www.phlp.org TTY: 1-866-236-6310

Volume 8, Number 6 December 2005

Class Action Lawsuit Challenges Passive Enrollment

On November 30, 2005, PHLP and Community Legal Services (CLS), filed a class action lawsuit in Federal Court against the Centers for Medicare & Medicaid Services (CMS), challenging the "passive enrollment" of dual eligible Pennsylvanians into Medicare HMOs. "Dual eligibles" are persons with Medicare and Medical Assistance (MA). Under the passive enrollment plan, MA recipients in Pennsylvania who were enrolled in Gateway, UPMC for You, Three Rivers MedPLUS+, Amerihealth Mercy, Keystone Mercy or Health Partners, as of August 15, 2005, have been automatically enrolled in each plan's affiliated Medicare HMO, unless they either "opted out" or selected a different Medicare drug plan.

The plan puts these MA recipients, most of whom have used the Medicare "fee-for-service" program

(Continued on page 7)

INSIDE THIS EDITION

Physical Health Plans Starting to Impose Co-pays, Service Limits

In August, 2005, DPW imposed several limits on the physical health services available to consumers through the MA Fee For Service (FFS) system. These changes included:

- A limit of 18 outpatient visits/year (with many exceptions) for all adults;
- A limit of 1 Medical Rehab Hospitalization/year for all adults;
- A limit of 1 Inpatient Hospitalization/ year for adults in General Assistance categories of MA;
- Prescription co-payments of $1 for generics and $3 for name brand drugs for recipients age 18 and older, with a

(Continued on page 11)

The New Medicare Prescription Drug Benefit Starts January 1, 2006—Are you ready?

The new Medicare benefit is about to begin and consumers have many important questions and concerns. These are some of the most common questions to PHLP's helpline.

1. I have not signed up for the Medicare benefit yet, do I need to do anything now?

For full dual eligibles (those who have Medicare and who get their drug coverage through Medical Assistance), you need to join a Plan by December 31, 2005 to make sure you are in a plan that covers your drugs. If you don't join a plan by this date, you will be put into a plan chosen for you. This may mean you end up in a plan that does not meet your needs (see next question). As of January 1, 2006, Medical Assistance prescription drug coverage will end except for a few medications (benzodiazepines, barbiturates, and some over-the-counter medications) not covered by the basic Medicare Part D plans.

Other people on Medicare, have until May 15, 2006 to join a Medicare Prescription Drug Plan to avoid paying a late penalty.

2. I am a full dual eligible. What will happen if I don't join a Medicare Drug Plan by December 31, 2005?

You will be put into a Part D plan that has been chosen for you. This will work one of two ways:

- **If you currently get your prescriptions covered through the Access card or through ION or AmeriChoice**, Medicare will randomly choose a stand-alone Prescription Drug Plan and enroll you in that plan for coverage starting January 1, 2006. You will use this prescription drug plan to get your medications, and you will continue to use your red, white and blue Medicare card along with your Access card for other medical services.
  - You should have gotten a notice from Medicare that tells you which plan they assigned you to effective January 1, 2006 if you do not join a Plan on your own. If you are not sure which plan you will be in, you can call 1-800-MEDICARE or check the Medicare website at www.medicare.gov.
  - You need to check and see whether this plan covers your drugs and works with your pharmacy. If not, you should join a different plan by the end of the year.
- **If you currently get your prescriptions through AmeriHealth Mercy, Gateway, Health Partners, Keystone Mercy, Three Rivers MedPlus+, or UPMC for You**, you

(Continued on page 4)

Ion Is Pulling Out as a Medical Assistance MCO

PHLP has recently learned that Ion Health Plan is terminating its contract with the state as a Medical Assistance Voluntary Managed Care Organization. Ion operates in 6 voluntary managed care counties-Erie, Cambria, Blair, Somerset, Jefferson and Mercer. They currently cover 20,500 members-85% of whom live in Erie county.

DPW is hoping to be able to transition Ion members into other Voluntary MCOs or into AccessPLUS by March 1, 2006. A notice will be sent out to all Ion members telling them they will need to change their MA plan and informing them of their options. Depending on what county they live in, consumers will be able to choose from these options: AccessPLUS, Gateway Health Plan, MedPLUS+ and UPMC for You. The Consumer Subcommittee of the Medical Assistance Advisory Committee has recommended that those who do not select another plan be assigned to Access Plus, since this will likely provide the broadest network.

Before they switch plans, consumers should call their primary care doctor to find out which other plans their doctor accepts. They should then choose a plan that will allow them to continue to see their doctor and any other providers that are important to them. Once a consumer is ready to enroll into another plan they will do it by calling ACS (the entity in charge of enrollment/ disenrollment across the state at **1-800-485-5998**.

This change does not affect anyone's eligibility for MA. It will also not impact the 1,200 dual eligible members of ION, who were already scheduled to be moved from ION to the Medical Assistance fee-for-service program on January 1, 2006. Check PHLP's website (www.phlp.org) for updates on this transition.

DOH Seeks Comments to Draft Regulations Establishing Hospital Charity Care Requirements

The Pennsylvania Health Department seeks comments to draft regulations, which would establish Charity Care Requirements for Hospitals. The DOH draft regulations would require that full charity care be provided to persons whose family income is below 200% of the federal poverty level. Hospitals would also have to establish policies providing discounted rates to patients whose income falls between 200% and 400% of the poverty level. Catastrophic protection would be extended to low-income or uninsured patients by limiting their payments to 30% of their annual household income. Hospital collection practices would be regulated to prohibit selling a patient's primary residence to pay for an outstanding hospital bill. It is likely that hospitals will strongly oppose the imposition of specific charity care obligations, especially those which set bright lines for which patients qualify for free care. Historically, hospitals have argued that how much care a hospital wishes to give away, and to whom, should be established by each hospital, consistent with their mission and resources.

The draft regulations are posted on the DOH website at: http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=337&q=242161&healthRNavrad73550=|# To make comments, click on the excel version of Chapter 101, and type your comments in column B, opposite each regulation. Save your comments and send them to the Health Department by emailing them to: FacilityRegulationCoordinator@state.pa.us

(Continued from page 2)

will likely be enrolled into a Medicare HMO operated by the same company. This means that you could be restricted to a network of doctors and you may need referrals to see specialists. You should have gotten a letter about this change in October 2005.

- If you have not already done so, contact that Medicare HMO to find out whether all of your providers and suppliers are in the plan's network and to find out whether all of your drugs are covered. If the Medicare HMO will not meet your needs, you should join a stand-alone Prescription Drug Plan (PDP) by December 31, 2005. A stand-alone plan is just covers prescription drugs. If you join a PDP before this date, you will keep your Original Medicare (red, white, and blue card) and you will not be enrolled in the Medicare HMO.
- If you called to opt-out of the Medicare HMO by October 31, 2005, Medicare will auto-enroll you in a Plan effective January 1, 2006 unless you join a Plan on your own by the end of the year.
- If you called to opt-out after October 31, 2005, you must join a Medicare Prescription Plan before the end of the year to make sure you have drug coverage after January 1, 2006. Medicare will NOT automatically enroll you into a Plan if you do not choose one on your own.

3. There are so many choices, how do I know which Plan is best for me?

There are a dozens of plans to choose from, so comparing all the options is proving to be difficult for many consumers. Each plan has different costs, covers different drugs, and works with different pharmacies. Here are some questions you should ask before joining a Plan.

- Does the plan cover the drugs I take (check dosage and quantity, too)?
- Does the plan have any special rules for my drugs (i.e., requiring prior authorization)?
- Can I continue to go to the same pharmacy I go to now?

If you are looking at a Medicare Advantage Plan (Medicare HMO), you should also be asking these additional questions:

- Are my doctors, specialists, hospitals, and other providers or suppliers in the HMOs network?
- Will I need referrals from my primary care provider to see specialists?

The following resources are available to help consumers and/or people who are trying to help consumers with the Medicare Prescription Drug Benefit:

Medicare: 1-800-MEDICARE (1-800-633-4227 or 1-866-486-2048-TTY)
www.medicare.gov –Compare Prescription Drug Plan tool
Apprise: 1-800-783-7067

4. Once I join a Plan, will I be able to change Plans?

(Continued on page 5)

(Continued from page 4)

Dual eligible consumers will be allowed to change plans at any time. Other consumers will be locked into their Medicare Prescription Drug Plan after May 15, 2006. These other consumers will be allowed to change plans under the following situations:

- Once a year during a six week period starting November 15 and ending December 31.
- If they qualify for a Special Election Period (for example, moving out of the plan's service area or entering or leaving a nursing home).

5. How much will I have to pay for the Medicare Prescription Drug benefit?

Every plan's costs are different. All plans have premiums, some have yearly deductibles, and all have co-pays. You will be subject to the costs of whatever plan you join unless you qualify for a subsidy.

Any dual eligible (i.e. people with both Medicare and Medical Assistance—even if Medical Assistance just pays the Medicare Part B premium) will automatically get the full subsidy. This means you will not pay a premium (as long as you join one of the 15 stand-alone prescription plans listed below), you will not have a deductible, and you will only have small co-pays for your medications. You will pay between $1 and $5 per covered drug depending on your income and whether a drug is generic or brand name.

These are the plans to choose from if you are a full dual eligible or if you otherwise get a full subsidy:
Aetna Medicare Rx Essentials (800-213-4599**)**
First Health Premier (800-588-3322)
Blue Rx Basic (888-697-8714)
Humana PDP Standard (800-281-6918)
Community Care Rx BASIC (866-684-5353)
PacifiCare Saver Plan (800-943-0399)
Prescription Pathway Bronze Plan (800-825-8200)
Amerihealth Advantage Rx Option 1 (866-456-1695)
Advantage Star Plan (877-279-0370)
Silver Script (866-552-6106)
Medicare Rx Rewards (866-892-5335)
AARP Medicare Rx Plan (888-867-5564)
United Medicare MedAdvance (888-556-7047)
Wellcare Signature (888-423-5252)
YOURx Plan by Medco (800-758-3605)

If you join a plan that is not on this list, you will have to pay a portion of the monthly premium. You will still only have co-pays of $1-$5.

6. What if I need a prescription filled in January before I get an identification card from my Plan or if I do not know which plan I am in?

(Continued on page 6)

(Continued from page 5)

Medicare has taken steps to make sure all full benefit dual eligibles get Medicare drug coverage on January 1, 2006. If you are a full dual eligible and you show your Medicare and Medical Assistance card at the pharmacy, there is a system that allows the pharmacy to find out which Medicare Prescription Drug Plan you have.

If, for some reason, you are not enrolled in a plan, there is a process to allow you to get your medication and for Medicare to facilitate your immediate enrollment into a Medicare PDP.

If you have not received a card, but you have joined a plan, you should take any information you have to the pharmacy. This may be a confirmation number, a letter from the plan or any other notification about joining a Medicare Prescription Drug Plan.

7. What if I cannot get a drug I need through my Medicare Prescription Drug Plan?

You should ask the Plan about their transition policy and whether that policy covers a one-time fill of a prescription medication not on the plan's formulary. You or your doctor can also request a formulary exception from the Plan. Each plan will have its own exception process, so you should ask your plan about this. If you request an exception, your doctor will need to send the plan information about why you need a drug that is not on the plan's formulary. The plan then decides whether or not to cover the drug. There are further appeal options if the plan denies you the drug. You can contact our Helpline if you need assistance with this.

If you are a dual eligible, you can also think about changing prescription drug plans. You are able to change plans at any time. If you do change plans, you will be in the new plan on the first of the following month.

8. What if I cannot afford the co-pays for my medications?

Unfortunately, there is no requirement that the pharmacy must give you your prescriptions if you cannot pay the Medicare co-pay. Pharmacies have the option of waiving co-pays on a case by case basis; however, they are not required to do so. If you are denied medications because you cannot pay the Medicare Prescription Drug Plan co-pays, please contact our Helpline.

For up to date information, please see the Pennsylvania Health Law Project website at www.phlp.org. If you have questions or encounter any problems and you would like individual assistance, please contact our helpline at 1-800-274-3258 or 1-866-236-3610 (TTY).

Medicare Part D Multilingual Helplines Established

Two national organizations have set up helplines to help individuals with the Medicare Part D enrollment process for Spanish, Chinese, Korean and Vietnamese speakers. The National Alliance for Hispanic Health has set up a hotline for Spanish speaking individuals. Callers can get help with applying for low-income subsides as well as help with choosing a plan. The hotline number is 1-866-783-2645 and the hotline is open Monday – Friday from 8am – 6pm.

The National Asian Pacific Center on Aging has helplines for Korean, Chinese and Vietnamese speakers, as well as English speakers. The helplines can also help callers enroll in low-income subsidies and choose Medicare Part D plans. The numbers for the National Asian Pacific Center on Aging helplines are:

English 1-800-582-4218	Chinese 1-800-582-4218
Korean 1-800-582-4259	Vietnamese 1-800-582-4336

(Continued from page 1)

in the past for virtually all care except prescription drug coverage, at risk for losing the right to see their doctors, hospitals, durable medical equipment suppliers, psychiatrists, etc. These health care providers will be unavailable to the passively enrolled population unless the providers enroll in and are accepted into the Medicare HMO's limited provider network.

The lawsuit, Erb et al v. McClellan et al (Civ. Action No. 05-W-6201), which was brought in the US District Court for the Eastern District of Pennsylvania on behalf of several affected individuals plus Action Alliance of Senior Citizens of Greater Philadelphia, and the Center for Advocacy for the Rights and Interests of the Elderly, raises three legal challenges. First, forcing people into Medicare HMOs without their consent violates the Medicare statute. Second, the failure of CMS to promulgate regulations governing passive enrollment violates the Administrative Procedure Act. Finally, the failure of the federal government to notify the affected individuals of their effective disenrollment from original Medicare violates due process rights of the recipients.

The lawsuit seeks to enjoin CMS from proceeding with passive enrollment, or in the alternative, to require CMS to create, publicize and enforce important safeguards to protect passively enrolled individuals against the loss of continuity of care and services. The case has been assigned to Judge John Padova. A Preliminary Injunction motion was filed on December 21, 2005.

What If I Can't Pay My Medical Assistance Prescription Co-Pays?

In August, 2005, DPW implemented prescription co-pays in the MA Fee For Service (Access) system for all those consumers who are 18 years old and older. The co-pays are $1 for generic drugs and $3 for name-brand drugs. The Physical Health Managed Care Plans are also starting to implement these prescription co-pays. Many consumers have called PHLP asking what they should do if they cannot afford these prescription co-pays.

If you cannot afford the co-pay when you go to the pharmacy, tell the pharmacist you cannot afford to pay the co-pay(s). The pharmacist should take your word and give you the medication unless they have evidence that shows you can afford the co-pays. Under Medical Assistance rules consumers cannot be denied a drug by a pharmacy if they cannot afford the Medical Assistance co-payment for the drug.

If you cannot afford a prescription co-pay but your pharmacist refuses to give you the medication, you should call the Medical Assistance Call Center (if you use the Access card to get drugs) at 1-866-542-3015 or call your Physical Health Plan (if you are enrolled in an MCO). For questions or problems related to your Medical Assistance prescription co-pays you can also call PHLP's Helpline 1-800-274-3258.

Medical Assistance Transportation in Philadelphia up for Re-Bid

On October 1, 2005, Medical Transportation Management (MTM) started providing Medical Assistance Transportation Program (MATP) services in Philadelphia County.
MTM replaced Wheels of Wellness as the MATP contractor. As a result of a legal challenge to the bid process under which MTM was selected last Spring, the contract is being re-bid. The new request for proposals was posted by the state on November 28, 2005, and final proposals are due on January 13, 2006. Following a 90-day transition period, the successful bidder is expected to assume full control of the program in August, 2006. In the meantime, MTM is staying on as the interim contractor.

There have been many problems associated with the changeover to MTM, and steps have been taken to try to address the issues. Many of these changes were systems related, such as adding new phone lines so that people can more easily reach MTM staff, and improving the ride scheduling system, which was decentralized under MTM. MTM employs many of the same transportation subcontractors as Wheels.

MTM instituted some changes. MTM requires non-urgent medical trips to be scheduled three days in advance. Those who require a ride on the day they are calling, or within three days due to an urgent medical condition are entitled to a ride, and should ask for a supervisor if they meet resistance. MTM will call the doctor's office to confirm that the appointment is urgent and arrange

(Continued on page 12)

Consumers Urge Spit Tobacco Tax, Reductions in MA Subsidies for Commercial Insurance and Cost Shifting to Medicare in Effort to Save Pennsylvania Medicaid Dollars

During the Fall, DPW sponsored a "Listening Tour", in an attempt to get public input on how best to address financial pressure on the Medical Assistance (MA) program. The Consumer Subcommittee of the Medical Assistance Advisory Committee testified in support of a number of measures to raise funds or reduce expenditures without hurting recipients. Among the recommendations of the Subcommittee were that Pennsylvania join the other 49 states in taxing non-cigarette tobacco products such as cigars, pipe and spit tobacco. Consumers testified that this measure could raise $100 million dollars. They also recommended that the state prohibit commercial insurers from excluding autism treatment coverage, expand mandated mental health coverage, and require inclusion of dependent adult children with disabilities on parents' medical policies. These measures would keep insurers from shifting costs to the state's Medicaid program.

Consumers urged the state to eliminate the resource test for the Medicare savings program, which would allow more persons to qualify for the Medicare low-income drug subsidy and save the state Pharmaceutical Assistance Program (PACE) dollars. And they recommended that the state establish a program to recover from Medicare any home health expenditures by the MA program on behalf of dual eligible (Medicare and Medicaid) recipients. Yvette Long of Philadelphia Welfare Rights Organization delivered the testimony on behalf of the Subcommittee at the listening session in Allentown. The testimony of most of the participants in the 8-city listening tour are posted on DPW's website at: http://www.dpw.state.pa.us/lowinc/matour/default.htm

Pennsylvania Implements Preferred Drug List

Pennsylvania is implementing a Preferred Drug List (PDL) for individuals who receive prescription drugs from Medical Assistance. A Preferred Drug List means that medications on the list will not require prior authorization. Medications that are not on the list can be obtained if the Department of Public Welfare approves a prior authorization request. Prior authorization means that a doctor must ask the Department of Public Welfare to cover the medication. The doctor must explain why the consumer needs the non-preferred drug. If the Department denies coverage of the non-preferred drug, the consumer can appeal the decision

Some medications do not need prior authorization, even though they are not preferred, if the consumer has been taking the drug for a certain period of time. The drugs which will be automatically granted prior authorization are several mental health related drugs. One set of drugs that will be covered are: Adderall, Cylert, Cymbalta, Desoxyn, Desyrel, Effexor IR, Lexapro, Nefazodone, Paxil CR, Provigil, Prozac, Prozac Weekly, Remeron, Ritalin LA, Sarafem, Serzone, Strattera, or Wellbutrin XL. These drugs will be covered automatically if a consumer had a prescription filled for the medication 90 days prior to December 1 and the consumer's doctor thinks he or she needs that drug. Symbyax or Zyprexa will not require prior authorization if the consumer filled a prescription for either drug within the past 365 days and the consumer's doctor thinks that he or she still needs the medication.

The preferred drug list took effect for

(Continued on page 12)

OMHSAS Releases
"A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults".

In November 2004, a Recovery Workgroup was formed through the DPW Office of Mental Health and Substance Abuse Services (OMHSAS). This Workgroup was brought together by invitation to discuss the development of a working blueprint for Pennsylvania to develop a recovery-oriented public mental health service system for adults. The Recovery Workgroup was comprised of consumers, family members, advocates, providers, county administrators and OMHSAS staff. The task of the Workgroup was to explore how to transition the Pennsylvania mental health system from a medical model into a more recovery-oriented approach and to create a written tool for counties and others to use to accomplish this grand task. This task was incorporated as a Priority Project of OMHSAS and was approved by the OMHSAS Advisory Structure with the specific charge to develop a blueprint to help frame and guide the transformation.

After many months of diligent and dedicated work, research and dialogue, this "Blueprint for Recovery", was released by OMHSAS this Fall, entitled, "A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults." It is a 76-page document. This document is designed to be a "living-breathing" document and not a "set in stone" plan. *A Call for Change* includes an introduction explaining the need for change, a history of the roots of recovery in mental health, a description of what recovery looks like and the indicators of a recovery-oriented service system. The document outlines the basic recovery domains or benchmarks that must exist in order for a system to be recovery focused.

These basic recovery domains include:

* Validated Personhood
* Basic Life Resources
* Rights & Informed Consent
* Treatment Services
* Addressing Coercive Practices
* Self-Care, Wellness & Finding Meaning
* Outcome Evaluation & Accountability
* Person Centered Decision-Making & Choice
* Connection-Community Integration, Social Relationships
* Peer Support/ Self-Help
* Participation, Voice, Governance & Advocacy
* Worker Availability, Attitude & Competency

For each of these basic domains, the document outlines in a chart format, the elements of a recovery-oriented system relative to that domain and ways in which that indicator can be demonstrated. For example, in the *Recovery Domain 1: Validated Personhood*, one key indicator is demonstration of hope and positive expectations. One way in which a system could demonstrate this indicator would be through consistent use of person-first language in all written and verbal communication such that people are not identified as their diagnosis. So it would never be said that "Tom is a schizophrenic" but instead the appropriate language used would be, "Tom is a person who has schizophrenia". In *Recovery Domain 2: Person Center Decision-Making & Choice*, one element or indicator is the existence of person-centered/ person-authored service planning. This indicator would be evidenced in a mental health program by, for example, the inclusion of the persons' own language regarding their service plan goals and objectives. This same indicator would be demonstrated at the county or statewide level by the mandate of all

(Continued on page 11)

(Continued from page 10)
contractors and local systems to show evidence of person-centered planning. For each of the 12 Recovery Domains there are identified indicators and subsequent ways that a particular indicator can be demonstrated by a mental health program or service and by the county, region or state. In addition to the 12 recovery domains, the document includes the challenges and barriers of the transformation toward a recover-oriented system.

The intent of this document is that it be widely disseminated, read, reviewed, discussed and debated. Ultimately, there must be some consensus of agreement among stakeholders regarding the contents, ideas and beliefs contained in this document, before the transformation to a recovery-oriented system can occur. Across the state, the stakeholder community of consumers, family members, providers, advocates and county & state mental health administrators are encouraged to read, share and discuss this document frankly and respectfully with one another. To begin this process, *"A Call for Change: Toward a Recovery-Oriented Mental Health Service System for Adults",* can be found on the Pennsylvania Mental Health Consumers Association website at www.pmhca.org.

(Continued from page 1)
6 month out-of-pocket limit of $180 for GA population and $90 for all others. None of these limits/co-pays apply to pregnant women.

DPW reduced the capitation payments to the MA-participating Physical Health Managed Care Plans (MCOs) to reflect the MA FFS co-payments and caps on services. That is, DPW assumed that the health plans would impose all of the limits and co-payments. The MCOs were permitted but not required to impose some or all of the same caps and co-pays used in the FFS system, but could not impose any that differed from FFS. Health plans were required to give their members a 30-day advance notice of any changes.

There is variation among the plans. In the SW Region, for example, UPMC for You is not imposing the 18 outpatient visit limit, whereas Gateway and Three Rivers are doing so. In the SE Region, Health Partners and Keystone Mercy are not charging a copayment for federally qualified health centers, whreas AmeriChoiceis doing so.

PHLP will be posting on its website two charts, prepared and distributed by DPW, which show which co-payments and caps each plan will impose. One chart is for the GA population and the second is for the other MA Adult population. PHLP's website is www.phlp.org.

With regard to any service caps they may impose, the MCOs must develop an exceptions process that consumers/their physicians may use to seek approval for needed services that exceed the caps. The exceptions process will be administered by the MCO which will review and decide on the requests.

What About the Behavioral Health Caps?
In August DPW also implemented caps on some behavioral health services in the FFS system-specifically limits on inpatient hospitalization days, partial hospital hours and psychiatric outpatient clinic services. Unlike the PH-MCOs, DPW decided not to reduce its capitation payments to the Behavioral Health (BH) MCOs. As a result, <u>the BH-MCOs are not permitted to implement any of these service caps.</u>

(Continued from page 9)
Medical Assistance recipients in Fee for Service on December 1, 2005. When and if the PDL will be implemented in HealthChoices has yet to be determined by the Department. Consumers who receive both Medical Assistance and Medicare will be subject to the preferred drug list, until they begin receiving their prescription drugs from Medicare on January 1, 2006.

(Continued from page 8)
transportation.

If a ride is late recipients can check on the status of a ride or arrange alternate transportation, by calling MTM at 1-888-240-6588, and selecting option 1. Complaints about MTM should be addressed to the MTM Complaint hotline 1-866-436-0457. Those who are not getting satisfaction should call PHLP at 1-800-274-3258.

Pennsylvania Health Law Project
Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106