Topic	Question	Answer
Common Medical Marketing Area (CMMA)		
	What is CMMA?	The Common Medical Marketing Area (CMMA) is the geographic area from which a community customarily obtains its medical care and services. The CMMA is not necessarily set by geographic or county borders. Rather, the CMMA can vary depending upon the medical specialty or services required that are accessible locally, as well as the individual needs of each enrollee
	How is CMMA calculated?	Use definition outlined on July 9, 2025, webinar slides. For Opioid Treatment Programs (OTPs), Comprehensive Outpatient Programs (COPs) and Outpatient Programs (OPs), the CMMA includes all OTP and OP facilities within the enrollee's county or borough of residence. Additionally, the CMMA also includes any OTP, COP or OP facility outside of the enrollee's county or borough of residence where the distance is less than or equal to the maximum average distance traveled to receive these services within the county or borough. Members using public transportation in NYC (or other regions of the state that utilize public transportation)

		can continue to travel to distant programs if they continue to use public transit.
	Where can I see who has an upcoming 2020 that will expire?	Log into the MAS system as shown in the July 9, 2025, webinar. Additionally, these files are sent weekly via the Health Commerce System (HCS).
	Why doesn't the CMMA measurement seem correct?	Many variables are considered for the CMMA calculation. Each enrollee will have a unique distance based on their address in ePaces.
	What is the most efficient way to update this address?	The enrollee is responsible for updating their address with the Local Department of Social Services (LDSS) and/or New York State of Health, Health Plan Marketplace within 10 business days, in accordance with DSS policy. CMMA will be calculated based on the address in ePaces.
	Will areas like NYC with a dense population of OTP/OP facilities limit or remove one's ability to choose a program?	Not necessarily the case; it depends upon the patient's closest OTP, COP or OP to their address. Then, there are three options if they're attending a program outside their CMMA (remain in-care without covered Medicaid transportation by taxi, maintain in the same program with use of carfare, or relocate to a closer program within their CMMA).
	What happens when a provider will not accept someone into their program even though it's within the CMMA?	If the closest provider is not able to accept a patient or is at capacity, by default the next available provider would be within the CMMA. Transportation outside of CMMA requires Form 2020 to be completed by a

		referring (not receiving) provider to document that treatment is not available locally The program seeking to get a patient into another program should reach out to the SOTA Team (SOTA.mailbox@oasas.ny.gov) to let us know of any barriers to care; we can reach out to the program that is not accepting the patient to get a better understanding of any issue (CAVEAT: This is particularly important f the program was not afforded a reason why the other program is refusing to accept the patient).
	If i need to explain what an CMMA is to a member what should I tell them?	The Common Medical Marketing Area (CMMA) is the geographic area from which a community customarily obtains its medical care and services. The CMMA is not necessarily set by geographic or county borders. Rather, the CMMA can vary depending upon the medical specialty or services required that are accessible locally, as well as the individual needs of each enrollee. •If the closest provider is not able to accept a patient or is at capacity, by default the next available provider would be within the CMMA. •Transportation outside of CMMA requires Form 2020 to be completed by a referring (not receiving) provider to document that treatment is not available locally.

		https://masvmwp01.medanswering.com/wp-content/uploads/2025/06/OTP-OP-CMMA-Transition-Enrollee-Information-5.29.25.pdf
	How does CMMA work with health systems that want to keep enrollees within their network of providers, but those providers are outside of the CMMA.	Generally, CMMA doesn't consider keeping an enrollee in a health systems network. To remain complaint with CMS guidance enrollees should go to the nearest qualified medical provider.
	If a patient resides in a shelter and is relocated to a different shelter outside the CMMA, do they need to move treatment also?	CMMA is based on the enrollees address in ePaces. If an enrollee moves, they should update their address to maintain receiving the transportation benefit.
	What is the definition of a long distance for MAS?	Long distance does not have a standard definition, and programs should refer to the Common Medical Marketing Area look-up tool within the MAS portal to determine which programs are within the member's CMMA. For OTPs, COPs and Ops, the CMMA includes all OTP and OP facilities within the enrollee's county or borough of residence. Additionally, the CMMA also includes any OTP, COP or OP facility outside of the enrollee's county or borough of residence where the distance is less than or equal to the maximum average distance traveled to receive these services within the county or borough.
Going out of CMMA		

	Are you forcing enrollees to go to an in CMMA medical provider?	No. Enrollees are transported to the patient's closest qualified medical provider. However, an enrollee may continue to go to the distant OTP if they choose to their address. Then, there are three options if they're attending a program outside their CMMA (remain in-care without covered Medicaid transportation by taxi, maintain in the same program with use of carfare, or relocate to a closer program within their CMMA).
	Is there any way for patients that are outside the CMMA to remain at their assigned clinic?	This would need to be for extenuating circumstances only and considered on a case-by-case basis, should the three options still not being optimal (remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA).
	In cases where our OTP provides OTP services and also addiction psychiatry, can we keep patients in our clinic when the OTP closest to home does not have the ability to provide psychiatry services? Many rural communities lack psychiatry services	This would only be considered on a case-by-case basis, should the three options still not being optimal (remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA).
	What if patients are banned from receiving services from a certain location/program?	MAS will review justifications submitted on 2020-forms and determine if travel outside the member's CMMA is necessary. Any documentation that supports the

		justification, such as a court order, can be submitted to MAS with the 2020-form.
	What if a patient only attends the program 1x monthly and has been with the program for numerous years with coordination of care and successful recovery outcomes	This would only be considered on a case-by-case basis, should the three options still not being optimal (remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA).
	What if no other OTPs in the person's CMMA will accept the person due to treatment such as opioid-based or benzo. based treatment? Some OTPs DO not provide such important patient care	There may still OTPs out there that have providers who take a harder line (e.g., such as a case where patients aren't accepted based on their benzodiazepine use or other factors). For continuity of patients' care, we would like to ensure this would not cause the patient(s) from bouncing between programs for fear of them being lost.
	-What happens if a client is refusing to go to any of the other programs closer to them for various reasons? Such as - it could be a risk/triggering for them to be there.-	This would only be considered on a case-by-case basis should the three options still not being optimal (remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA).
	What about OP clinics that offer MH services that are out of the areas?	A regular 2020-form can be submitted when ongoing treatment from a program outside the member's CMMA is clinically necessary. The 2020-form must be completed by a referring provider and cannot indicate a referral to the provider's own program. MAS will determine when the submitted 2020-

		form can be approved based on the submitted justification.
	How does it work if a patient has unstable housing?	CMMA is based on the enrollee's address in ePaces. If an enrollee moves, they should update their address to maintain receiving the transportation benefit. The enrollee is responsible for updating their address with the Local Department of Social Services (LDSS) and/or New York State of Health, Health Plan Marketplace within 10 business days, in accordance with DSS policy.
	Will guidance be provided to all levels of care to ensure patients transitioning to different levels of care are staying within their CMMA. Could patients potentially wait to get into treatment (i.e. halfway houses) as many halfway houses may be out of a patient's CMMA. The county may not be changed in Medicaid for temporary housing situations	This would need to be considered on a case-by-case basis, should the three options still not being optimal (remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA).
	If a standing order does not expire until December - is that client still expected to transfer to a program in their MMA by end of July?	The first day (day 1) that a program should start working on transitioning a member closer to their home differs by patient and is no earlier than July 28, 2025; Day 1 is 4 weeks prior to the expiration of patient's standing

		order for transport. Some members may want to transfer to a program closer to their home before their standing order expires and, in those cases, the program should assist the member in finding a suitable location.
	What happens if the enrollee refuses to relocate to a closer provider?	There are still three options remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA.
	Will there be exceptions for clients who are unable to attend a facility that is closer to them due to personal conflicts, privacy, or discharge status not being able to attend the program closest to them?	This would need considered on a case-by-case basis, should the three options still not being optimal (remain in-program without Medicaid transportation by taxi covered, utilize public transportation [if feasible], or transfer to the provider within the patient's CMMA).
	Admittedly it should be rare, but what do we do if we admit a patient but then the facility we are referring to denies due to clinical concerns, not capacity? Some programs admit with more/less discretion than others.	This should be noted on a 2020 form. It will be brought to the attention of OASAS. OASAS along with DOH and MAS can collaborate on how to best proceed.
	What is the process for asking for exceptions - that someone outside a zone should stay at the clinic? For example, a patient who is blind and it	MAS will review justifications submitted on 2020-forms and determine if travel outside the member's CMMA is necessary. Any documentation that supports the

	would be a severe hardship to change programs.	justification can be submitted to MAS with the 2020-form.
2020 Form		
	Who completes the 2020 form?	While an enrollee is transitioning to a program within their CMMA, a "grace period 2020 Form" may be completed by their existing program that allows them to continue receiving treatment at their current out-of-CMMA program for a limited time; a grace period 2020 can be completed for a period not exceeding 60 days to ensure continuity of treatment for the member. For all non-grace period 2020 Forms, the receiving provider is prohibited from completing the NYS 2020 Form. Per DOH policy, a referring medical provider must complete a 2020 Form (found within the MAS Medical Provider Portal)
	When does the 2020 form expire?	2020 form expiration dates can be found on the enrollee profile page in the MAS system under the "Forms" tab.
	How do we know the status of a 2020 form once submitted?	The review process for the NYS 2020- Form begins once the form has been submitted, and it may take up to 7-10 business days to complete the review. *A member of the MAS Utilization Review team will be in touch with you if any additional information is needed. You may also check on the status of a form under the tab labeled "Forms" on the enrollee profile in the MAS system.*

	Can we see why a 2020 was denied?	The status of a 2020 form will be updated for the medical provider to see in the secure MAS portal.
	If a standing order does not expire until December - is that client still expected to transfer to a program in their MMA by end of July?	The first day (day 1) that a program should start working on transitioning a member closer to their home differs by patient and is no earlier than July 28, 2025; Day 1 is 4 weeks prior to the expiration of patient's standing order for transport. Some members may want to transfer to a program closer to their home before their standing order expires and, in those cases, the program should assist the member in finding a suitable location.
	If a program has a waitlist, they would be required to complete all 2020 forms for the clients they cannot accept?	The receiving program with a waitlist will need to complete a 2020 indicating such.
	If the closer OTP is unable to accept new patients, a new 2020 should be filed by who? The current OTP or the one that cannot accept the patient?	The 2020 would be completed by the program who cannot accept the patient. Please refer to the July 9th webinar slide deck for more information on this option (see step 5c).
	If a 2020 is submitted for a simple pickup or drop off time change how long does it take for the form to be reviewed and approved?	A NYS 2020-Form is not required for a pickup or drop off time change.

Grace Period 2020 Form		
	What is a grace period 2020 form?	To continue attending their current program during the 60 days, the program must complete a 'Grace Period 2020-Form.' After 60 days, members with a need for services not available locally must have an approved 2020-Form filed for transportation to be covered. The grace period 2020 form can be found on the MAS medical provider portal.
	Who can complete a grace period 2020 form? How long is it good for?	While an enrollee is transitioning to a program within their CMMA, a “grace period 2020 Form” may be completed by their existing program that allows them to continue receiving treatment at their current out-of-CMMA program for a limited time; a grace period 2020 can be completed for a period not exceeding 60 days to ensure continuity of treatment for the member.
	Where is the grace period 2020 form located?	There is only one 2020-Form. When this form is submitted with the intent to extend approval for a member to travel to their current, distant program for a period of 60-days after their standing order for transportation expires, DOH and MAS think of this use as a “Grace Period 2020. Programs will select “Substance Use Disorder Treatment Grace Period” from the “Justification Reason” drop down and note in the “Justification” section of the form the timeframe (up to 60 days).

	Is the grace period 2020 form different from a regular 2020 form?	There is only one 2020-Form. When this form is submitted with the intent to extend approval for a member to travel to their current, distant program for a period of 60-days after their standing order for transportation expires, DOH and MAS think of this use as a "Grace Period 2020." In the justification reason drop down within the 2020-form, 'Substance Use Disorder Treatment Grace Period' is an option:
	If we want to request transportation beyond the 60-day grace period, because it's clinically appropriate for them to stay in this specific treatment program- would we then do the regular 2020 form?	Transportation beyond the grace period would be considered case by case. Generally, no self-referrals will be allowed past the grace period. A regular 2020-form can be submitted when ongoing treatment from a program outside the member's CMMA is clinically necessary. The 2020-form must be completed by a referring provider and cannot indicate a referral to the provider's own program. MAS will determine when the submitted 2020-form can be approved based on the submitted justification.
	During Lesley's presentation, did I hear correctly that the Grace Period 2020 is ending in 2026?	No; to clarify, in Lesley's presentation, in the slide that said, "Step 6: Continue to repeat this process with all members who are traveling out of their CMMA in the four weeks prior to the expiration of the member's standing order. This process will conclude in early 2026."

Public Transit		
	We only distribute MetroCard's and use no other forms of transport; how does all of this interact with PTAR?	Members using public transportation in NYC can continue to travel to distant programs if they continue to use public transit.
Health Commerce System (HCS)		
	When we inquired with Health Commerce System to get access to the report, they weren't able to add that as of yesterday. They informed us "Your organization type does not have that role."	For questions about the HCS please contact them directly.
	What is the health commerce system?	The Health Commerce System (HCS) has been developed by New York State Department of Health (NYSDOH) as a secure system for collecting and distributing data among state entities, health facilities/providers and partners. The purpose of this document is to: • Describe the policy that the user of the HCS must agree to and the conditions that must be met to obtain and retain an HCS account. • Enroll using the HCS User Account process to permit an HCS account to be established for a new user of the HCS. • Describe the policy for and methods of providing an existing user of the HCS with an association to this organization.

	How can we find out who is the contact you've as the appointed person for HCS? Would you be able to let us know?	Contact medtrans@health.ny.gov
	Only one user is able to access Health Commerce System? Backup users will need to be identified and enrolled.	We are working on adding the ability to add additional users. You can also utilize the MAS system to see upcoming expiring 2020 forms.
	How are we able to add contact person in the HCS?	Contact medtrans@health.ny.gov