National
MLTSS
Health Plan Association

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State Medicaid Agency Contract (SMAC) Development Process Timeliness Considerations

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.[1] Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration.

The annual SMAC development process requires significant coordination between state Medicaid agencies, health plans, and CMS - and this coordination will only become more important as the D-SNP integration requirements go into effect in 2027 and 2030. We recognize the progress that has been made in the SMAC development process over the last few years and want to acknowledge the time and effort that the Medicare-Medicaid Coordination Office (MMCO) has put into working with states and health plans to develop and execute their SMACs. In the following brief, we outline recommendations that we believe will continue to move the SMAC development process forward and highlight areas where there is a need for CMS' continued guidance and technical assistance.

Annual SMAC Development Process

In 2025, the MLTSS Association, in collaboration with the SNP Alliance, released a Recommended SMAC Development Timeline. Included in this timeline are required, annual milestones, including:

1. Medicare Advantage bid submission deadline
    a. Date: First Monday in June [this deadline is set in statute]
    b. Responsible Party: D-SNPs
2. SMAC submission deadline
    a. Date: First Monday in July [this deadline is set in the Medicare Managed Care Manual]
    b. Responsible Party: D-SNPs
3. Contracts fully executed
    a. Date: August 31st
    b. Responsible Party: D-SNPs/CMS
    c. Rationale: After D-SNPs submit their bid submissions to CMS, CMS goes through a thorough review. At the completion of the review process, CMS approves the bids for the upcoming plan year.

[1] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Highmark, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

The recommended timeline included additional milestones that are not set in statute or required by CMS that would support the SMAC development process. These milestones include:

1. States send major changes that will be included in the SMAC to health plans. This may include changes to integration levels, benefit design, supplemental benefits or aligned network requirements.
    a. Date: January (the year prior – e.g.: January 2025 for the Plan Year beginning in January 2026)
    b. Responsible Party: States
2. States send draft SMACs to D-SNPs. Drafts are informed by historical SMACs and discussions between the state and health plan.
    a. Date: March
    b. Responsible Party: States
3. Review and revisions of draft SMAC by D-SNPs and states, as necessary
    a. Date: April through May
    b. Responsible Party: States and D-SNPs
4. States send D-SNPs SMACs for final review and execution
    a. Date: Mid-June
    b. Responsible Party: States

These recommended milestones outline a process in which states and health plans have ample time to develop, review and revise their SMACs in advance of the annual SMAC submission deadline. We acknowledge that factors outside of state Medicaid agencies' control, such as decisions made during state legislative sessions, may make it difficult to adhere to an ideal recommended timeline. However, we believe that this timeline can still be a resource for states and health plans as a reference that can be adjusted to meet individual states' needs.

Recommendation: We encourage CMS to issue a model SMAC development timeline that incorporates these milestones, establishing a clear expectation for when draft and final contracts should reach D-SNPs relative to bid and SMAC submission deadlines. A model timeline would give states a concrete benchmark to plan against and give plans a shared reference point in their conversations with state partners. The MLTSS Association would welcome the opportunity to work with CMS to develop this timeline.

SMAC Development Challenges

Challenge #1: Delayed Delivery of Draft SMACs

In our recommended SMAC development timeline, a key milestone is the delivery of draft SMACs, which would be sent from states to D-SNPs annually in March. These draft SMACs would be informed by previous SMACs and conversations between states and health plans over the prior months. However,

MLTSS Association members have noted that states frequently do not provide draft SMACs by the end of March.

We want to first recognize the progress that has been made in recent years in the delivery of draft SMACs – there have been consistent, year-over-year improvements in the timeliness of these drafts, due in large part to MMCO's support and technical assistance to states.

We believe that it is important to highlight not only the progress that has been made, but the places where we believe there is room for improvement. Nearly half of all states included in an MLTSS Association analysis did not provide their first draft SMACs to D-SNPs until early to mid-April, and a handful not until June – less than a month before the SMAC submission deadline. This timing does not allow D-SNPs sufficient time to review the draft SMAC and provide feedback to states, nor does it provide states with sufficient time to make thorough edits to the SMAC before it must be submitted to CMS. More broadly, when a state shares an initial draft in June or a final contract in July, it becomes difficult to describe the process as truly collaborative. By that stage, there's limited room left for meaningful discussion, review, or joint problem-solving between the state and the plan. In practice, plans are often left with little choice but to accept what has been provided.

Late visibility into draft SMAC language is especially challenging when states introduce or expand mandatory supplemental benefit expectations. In recent SMAC cycles, several states signaled movement toward defined benefit packages—such as dental, vision, hearing, transportation, meals, over-the-counter benefits, fitness, personal emergency response systems, or other gap-filling benefits — introduced after product strategy, rebate allocation, and bid assumptions were already underway.

State supplemental benefit requirements that lack sufficient detail to support accurate bid development are an emerging challenge. When elements such as service frequencies, limitations, and prior authorization requirements are lacking or missing, MAOs must interpret requirements, often without the standard terms or details needed, to assess operational impacts and system configuration changes. This creates unnecessary risk for member abrasion.

Even when these requirements are well-intended and aligned to member needs, late-cycle introduction limits a plan's ability to evaluate cost, operational feasibility, vendor readiness, and overlap with Medicaid-covered services before the Medicare bid deadline.

Additionally, we note that in some states, wide variation occurs year-over-year in when the first draft SMAC is received, and this unpredictability can act as a barrier to effective planning for plans. When plans cannot anticipate when a state's draft SMAC will arrive, it becomes a challenge to sequence internal reviews and approvals or coordinate SMAC review against their own bid development work. Greater consistency, supported by a model timeline, would allow both states and plans to approach their contracting cycles with more clarity.

Delayed delivery of draft SMACs also causes friction with the annual Medicare bid submission deadline, which occurs annually on the first Monday in June. Some D-SNPs may have to submit their bids without

seeing their draft SMACs, which could contain changes to required benefits and services. Timely delivery of draft SMACs would meaningfully improve D-SNPs' ability to price and design their products accurately.

Challenge #2: Delayed Delivery of Final SMACs

In our recommended SMAC development timeline, the delivery of final SMACs from states to D-SNPs is also a key milestone, which should occur annually by mid-June at the latest. We want to highlight the progress that has already been made in the timeliness of the delivery of final SMACs. With each SMAC development cycle in recent years, there have been noticeable improvements in when final SMACs have been delivered, and we want to recognize the work that has gone into making these improvements possible. The recommendations we put forward below are intended to continue this momentum and provide states with the necessary support to continue to improve this process.

For the 2026 SMAC development process, an MLTSS Association analysis found that many states did not provide their final SMACs to D-SNPs until July – with some not sending final SMACs until after the SMAC submission deadline. In some instances, D-SNPs operating in multiple states received almost all of their final SMACs after the MA bid filing deadline in June. The delivery of final SMACs this late creates a significantly compressed timeframe for D-SNPs' downstream review, operational readiness, and submission to HPMS. This dynamic places pressure on D-SNPs, as the limited window between execution and CMS submission deadlines requires accelerated coordination and rapid turnaround. Additionally, this delay often results in health plans receiving a deficiency notice and needing to resubmit their bids.

Health plans have noted that states often include provisions within their final SMACs that were not included in draft SMACs, and often, these changes are made after states have discussions with and receive guidance from CMS. In one instance, a state changed the enrollment process for unaligned members after the deadline for bid submission and after SMAC signature, due to a conversation with CMS. Additional examples of issues caused by late submission of final SMACs include:

- One state sent a final SMAC with a mistake that impacted the execution of the organization's bid less than one business day prior to the deadline date for submission of the bid to CMS.
- One state edited their final draft in a way that affected the bid and will have a membership impact, four days after the bid submission deadline.
- One state introduced required supplemental benefits and then adjusted the scope of those benefits in the final draft, well after the business decision-making process about how to deploy the product in that market had taken place.

Challenges arise when changes are made to SMACs shortly before – or after – the SMAC submission deadline, which can cause meaningful business impacts, reduce the reliability of early SMAC drafts, cause duplicative administrative work, and produce questions for the state that have the effect of extending the SMAC implementation process later into the year. Additionally, plans are being asked to submit bids and make product decisions before they know the final requirements they'll be expected to meet. Ultimately, the result is less time to thoughtfully design and operationalize benefits for members.

Plans also need clearer guardrails around how state-directed supplemental benefit expectations should be funded. Where mandated benefits are expected to be financed through Medicare Advantage rebate dollars, every additional required benefit reduces the dollars available for other benefits, member supports, margin, and innovation. This can force plans to reduce flexibility in other benefit categories, absorb financial pressure, or redesign offerings late in the cycle. CMS guidance should clarify expectations for state-required supplemental benefits, including how states should consider rebate constraints, Medicaid overlap, and plan discretion before requiring benefit levels through the SMAC.

Recommendation: We support CMS' continued engagement with states on their SMACs early in the development cycle, so that state-federal discussions are reflected in draft SMACs and plans have time to act on them.

Recommendation: We recommend that CMS publish a frequently asked questions (FAQ) or a best practices document addressing the questions it most commonly receives from states during the SMAC development process. This would allow states to resolve routinely asked questions and reduce the volume of individual requests CMS receives.

Recommendation: CMS could consider establishing a structured change cut-off before bid submission for material SMAC provisions that affect benefit design, service area, eligibility, enrollment restrictions, reporting obligations, vendor arrangements, or funding. After that point, changes should be limited to technical corrections, unless there is a clear state or federal compliance necessity. This would preserve state flexibility while giving D-SNPs a reasonable opportunity to price, configure, and operationalize requirements before CMS bid and SMAC submission deadlines.

Challenge #3: Communication Barriers between D-SNPs and States

Communication between states and health plans throughout the SMAC development process is essential. States and plans must be able to ask questions, clarify assumptions, and provide edits throughout the process to ensure that the final SMAC aligns with the state's program goals and is in compliance with state and federal regulations.

MLTSS Association members have highlighted some instances where communication with their states during the SMAC development process did not work as intended, including:

- One plan reported that in a state, feedback was sent back in March asking for process clarification and timing related to network congruency attestations and marketing material approvals. The plan did not receive a response from the state**.**
- One plan reported that in a state, they received the first of four drafts of the SMAC in February, and the state indicated they were willing to work with MCOs for feedback and revisions. However, when inaccurate language was included in the third draft, the plan requested a meeting with the state. The state declined the meeting and declined the plan's proposed new language.

- One plan experienced situations where state guidance or requirement changes were communicated outside the formal SMAC document, such as through email or subsequent implementation discussions. When those communications materially affect benefit design, reporting, funding, or operational requirements, plans need a clear mechanism to capture them in the SMAC review process and confirm whether they require CMS submission, implementation tracking, or formal amendment.

Recommendation: CMS should encourage states to use a structured feedback process that requires acknowledgment of plan comments, especially when plans identify cost, feasibility, funding, member impact, operational readiness, or compliance concerns. A documented disposition process would reduce ambiguity, help plans understand whether proposed language was accepted or rejected, and support stronger implementation planning after SMAC execution.

Conclusion

SMACs are an integral piece of the integrated care delivery system, and must be carefully designed, reviewed, and executed. When properly and thoughtfully designed, SMACs are a powerful tool to move states' integrated care goals forward, ultimately improving the quality of care for dually eligible individuals. The SMAC development process is also administratively complex, and requires months-long collaboration between states and their D-SNP plans. MMCO has been an active partner to both states and health plans in their SMAC development processes, and we greatly appreciate their guidance and support. The MLTSS Association stands ready to support our members, states, and CMS as they consider ways to strengthen the SMAC development process.

If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,



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