State Medicaid Agency Contract (SMAC) 2026

Frequently Asked Questions

July 2025

Coordination Only D-SNP Conversion Policy:

1) Why does the Department believe plans will seek to convert their HIDE SNPs to CO DSNPs? Is this policy based entirely on the service area restrictions? If not, are there other policy developments under way that would encourage such conversions? Could the Department share its plans and the timeline for these developments?

   As stated in the SMAC, the State is responding to changes in the federal landscape. The Medicare Final Rule will see a projected 500,000 Medicaid FFS individuals need to change their DSNP or become aligned. MAP plans are already exclusively aligned.

   IB-Dual plans have the ability up until 2030 to perform outreach to their Medicaid FFS population.

   However, MLTCP is not exclusive to only dual-eligibles, and therefore, becoming exclusively aligned would not be possible for the program. Additionally, most members are unlikely to meet the eligibility criteria to enroll in MLTCP, meaning that individuals in DSNPs tied to MLTCP are the most likely to experience disruption. Consequently, the State believes some plans may choose to offer a CO DSNP rather than a HIDE SNP for MLTCP.

   In addition, the final rule will limit the CO DSNP space as the service area requirements will prohibit plans who are committed to integrated care from offering a FBDE DSNP in the same service area as their DSNP for integrated products.

2) Since the partial cap MLTC plan does not include a comprehensive risk contract, it is our understanding that a DSNP that is paired with an MLTC is not, by definition, paired with an Managed Care Organization, under federal regulations. Instead, it appears to be paired with a prepaid inpatient health plan, under 42 CFR 438.2. Thus, the limits on the number of DSNPs and product offerings that may be offered by an MAO, beginning in 2027, would not apply to the DSNPs that are paired with partial cap MLTC plans. Is that the Department's understanding?

   This is not the Department's understanding; the plan should confirm with CMS.

3) How does this DSNP-partial cap product offering align with Article II (J)(4) of the SMAC, which indicates that applicants for new product offerings must agree to provide the MAP benefits and must obtain a FIDE or HIDE SNP designation?
   Section II(J)(4) is for D-SNPs that do not have a Medicaid contract at the time of SMAC approval.

4) Will the Department entertain applications for new HIDE SNPs composed of a D-SNP and a partial cap plan? Will these DSNPs with companion partial cap plans (i.e., HIDE-SNPs) also have to meet all of the same requirements as MAP plans, except for exclusively aligned enrollment, categories of enrollment, and sponsorship requirements?
Yes, plans may still apply for a new HIDE-SNP tied to MLTC and must meet the requirements outlined in the SMAC. Existing HIDE SNPs may also remain.

5) Would it be required to limit new enrollment in the D-SNP to individuals enrolled in, or in the process of enrolling in, a related Medicaid MCO?
CO D-SNPs will be required to follow the Medicare Final Rule.

6) Would it be limited, beginning in 2030, to enrolling (or continuing to cover) individuals enrolled in (or in the process of enrolling in) an affiliated Medicaid MCO?
CO D-SNPs will be required to follow the Medicare Final Rule.

Benefits – Nursing Facility Services

7) Does the term "nursing facility services" include post-acute skilled nursing facility care (i.e., the Medicare benefit), long-term custodial care (i.e., the Medicaid benefit), or both?
DOH is describing the Medicaid benefit.

8) Is it inclusive of the 100 days covered by Medicare?
Medicaid is the secondary payer.

9) For members that exceed the 100 days of skilled care, the plan would cover any stay under the Medicaid long-term care services (e.g., non-skilled care) benefit until individual is ready for discharge. Can the Department confirm that this consistent with the Department's expectations? Yes.

Health Plans Without an Executed Medicaid Contract:

10) What is the nature of the "express written approval" required to enable enrollment of new individuals in the MAP or IB Dual plan (e.g., statement of agreement, HPMS, executed contract, other)? What is the timeline for approvals?
CMS sanction authority will end in 2025; therefore, additional language was necessary in the 2026 SMAC to outline what will occur when a Medicaid application has not been approved at the time of the SMAC signing.

11) Does the same approval process apply to service area expansions where the Health Plan has "an established contract" with the State?

Service area expansion approvals are not changing.

12) Please define "established contract"?
An approved and active Medicaid contract with DOH.

13) In regard to Integrated Product Offerings, can DOH please provide more information on the process for obtaining written approval in this circumstance?
CMS sanction authority will end in 2025; therefore, additional language was necessary in the 2026 SMAC to outline what will occur when a Medicaid application has not been approved at the time of the SMAC signing. Written approval entails DOH informing the plan they can begin enrolling.

Model of Care (MOC) :

14) Can DOH please coordinate its review of the MOC with CMS, so there are not multiple audits of the MOC throughout the year?
For this year, DOH plans on reviewing, not auditing, the Model of Care received from plans.

15) Please clarify whether the latest MOC should be submitted every year for HIDE-SNPs and FIDE-SNPs, even if there were no updates from the previous year.

A Model of Care that has been approved for multiple years does not need to be submitted to DOH annually. However, if there are any updates to the MOC that have been approved by CMS, the health plan should submit an updated document to DOH. The SMAC will be revised accordingly. Health plans will be required to submit currently approved MOC by September 1, 2025.

16) We would like to request a dedicated discussion with DOH and CMS on the end of the IAP demonstration and migration to the new unified process (ie. guidance review; notices and timing rules; removal of auto-forward process; MAP handbook changes).
DOH is happy to discuss the phase out of the MAP integrated appeals demonstration with impacted health plans.

HIDE D-SNPs:

17) Can DOH please confirm our understanding that the proposed changes to Section II.F.1 would not allow a plan that currently operates a HIDE-SNP aligned with MMC for IB-Dual to establish a new CO D-SNP?
Yes.

18) Can DOH confirm whether a current MLTCP aligned HIDE SNP can be transitioned to a HIDE SNP aligned with MMC for IB-Dual in the future? Would this require CMS approval, or can it be handled solely through DOH via the 2027 SMAC?
DOH does not have a prohibition against this transition. Plans would need CMS approval and to follow Medicare rules.

19) Can DOH please confirm our understanding that a current MLTCP aligned HIDE D-SNP can be converted to a CO D-SNP, using one Plan Benefit Package (PBP) to serve partial dual-eligibles and another PBP to serve full dual-eligibles in service areas where the plan does not offer MAP?
This is correct. However, the final rule service area overlap is not exclusive to MAP.

20) Can DOH please confirm that plans will be able to maintain current CO D-SNPs serving partial dual-eligibles only? We believe this is the case but seek DOH confirmation.
DOH does not have a prohibition against this transition. Plans should follow Medicare rules.

21) Please clarify the requirement limiting plans to one Plan Benefit Package ("PBP") type (e.g., HMO, PPO, POS) for CO D-SNPs.
Plans may only offer one plan type across ALL CO PBPs.

22) Please clarify if remaining a Highly Integrated Dual Eligible Special Needs Plan ("HIDE-SNP") impacts the ability to also offer a plan for full-benefit dual eligibles.
DOH does not fully understand the question; please reach out to the dual integration mailbox at: dualintegration@health.ny.gov.

23) Please confirm if existing HIDE D-SNPs will be permitted to continue operating regardless of whether the parent organization also operates a Mainstream Medicaid plan.
The 2026 SMAC does not prohibit plans from continuing to offer HIDE SNPs tied to MLTCP.

24) Please clarify if it is possible to apply for a new HIDE D-SNP aligned with Mainstream (for IB-Dual) while using an existing, differently aligned HIDE D-SNP operationally until the necessary Mainstream MCO contract is approved.
DOH does not fully understand the question; please reach out to the dual integration mailbox at: dualintegration@health.ny.gov.

25) Please clarify if a current managed long-term care-aligned HIDE D-SNP can be converted to a CO D-SNP structure, potentially offering two PBPs under that CO model – one for partial duals and one for full duals who are not eligible for MAP.
The 2026 SMAC allows MLTCP aligned HIDE SNP plans to end their HIDE SNP and create a CO DSNP with two PBPs.

26) Please clarify the process for transitioning an existing MLTC-aligned HIDE D-SNP to become a HIDE D-SNP affiliated with a Mainstream MCO in the future. Specifically, please confirm if this transition requires CMS approval or if it can be managed solely through DOH via the SMAC.

Health plans should discuss any approval requirements with CMS directly impacting D-SNP transition.

27) Please confirm that health plans can continue using their existing HRA tools incorporating questions on housing stability, food security, and access to transportation to meet the SMAC requirement for identifying health-related social needs.
Plans may utilize their own assessment tool. However, the plan must include the specific questions from the Accountable Healthcare Communities tool related to food security, housing stability, access to transportation etc.

28) Please affirm that plans will be able to maintain COs that service partial duals only.
Plans must follow Medicare rules; DOH does not have an exclusion against COs serving partial duals.

29) Please address concerns that the SMAC does not identify enrollment pathways (outside the default process) for full duals wishing to transition to an integrated product, or for partial duals eligible to join an aligned product via enrollment in the Plan's Medicaid product.
The SMAC does include language on the Medicaid FFS transition. The questioner should reach out to the Department regarding what partial duals the plan is attempting to enroll in the plan's Medicaid product.

30) Please clarify if the Fee-For-Service Integrated Benefits for Dually Eligible Enrollees ("FFS IB-Dual") pilot will be extended or become standard practice for all plans.
Every health plan with IB-Dual is eligible to apply for the FFS transition.

Other:

31) Does this amendment require any changes in comparison with the requirements implemented a year or two ago?
DOH does not fully understand what amendment this question is referencing. Can the questioner provide additional background at: dualintegration@health.ny.gov.