# Medicaid and CHIP Policy Implementation Roadmap

*version 1*

To assist states with their implementation and planning efforts, CMS developed the timeline below to reflect key provisions with policy or technology requirements for *selected* final rules and statutes that may require changes to state Medicaid Enterprise Systems (MES). These timelines are not inclusive of all regulatory provisions, nor are they inclusive of all regulations or statutes that may impact the Medicaid and CHIP programs, but instead focus on ones that might have potential systems impacts. Because each state Medicaid agency is unique , and these actions may impact each state and territory differently, this timeline is only meant as an illustrative reference guide and outlines key provisions in the selected statutes and final rules. States should review the final rules and/or statutes for a comprehensive list of provisions, and the content in each final rule is the official record. States should also review the applicability charts published as reference guides for each final rule for a full summary of all applicability dates for the final rules.

**Legend**

Access to Quality Services — Services
Data — Data
Medicaid Financing — Financing
Eligibility & Enrollment — E&E
Quality Improvement/ Performance Measurement — Quality
Reporting Requirements — Reporting
Enrollee Experience and Access to Information — Transparency

**Tags for Potential Medicaid Enterprise System Impacts**

- CHIP Managed Care System
- E&E
- MMIS Claims Processing
- MMIS Data Warehouse
- MMIS Financial Management
- MMIS LTSS
- MMIS Member Management
- MMIS PBM
- MMIS Provider Management
- Website

**IMPLEMENTATION CALENDAR YEAR**

2025 | 2026 | 2027 | 2028 | 2029 | 2030 | … 2034

**STATUTE OR REGULATION TITLE**

## *Working Families Tax Cut (WFTC) Legislation Provisions*

Public Law No. 119-21, July 4, 2025

**RHT Program funding is allocated to approved States over five fiscal years, beginning in fiscal year 2026 and ending in fiscal year 2030. For more information on the RHT Program, see https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview*

**Statutory Implementation Applicability Dates**

**Passage Date**
**July 4, 2025**

**7/4/2025**

- **Sec. 71101** Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs.
- **Sec. 71102** Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.

E&E

**Sec. 71111** Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.

Services

**Sec. 71113** Federal payments to prohibited entities.

**MMIS Financial Management** — Financing

**Sec. 71116** New provider payment rate limit for applicable SDPs in Medicaid.
**Sec. 71117** Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax

**MMIS Financial Management**
**MMIS Data Warehouse** — Financing

**12/31/2025**

**Sec. 71401** Rural Health Transformation Program - CMS must approve/deny state applications*

Financing

**1/2026**

**Sec. 71114** Sunsetting Increased FMAP Incentive

Financing

**10/1/2026**

- **Sec. 71109** Changes to FFP and eligibility for noncitizens in Medicaid and CHIP
- **Sec. 71110** Limit FMAP for emergency Medicaid services for individuals not eligible for Medicaid based on immigration status to the states regular FMAP

**E&E**
**MMIS Financial Management** — E&E

**Sec. 71115** Provider taxes - Change in threshold for hold harmless provision of broad-based health care related taxes.

**MMIS Financial Management** — Financing

**1/1/2027**

- **Sec. 71103** Reduce Duplicate enrollment under the Medicaid and CHIP programs
  - Develop process to regularly obtain enrollee address information
  - State managed care contracts to include the requirement that covered entities and plans transmit enrollee address information.
- **Sec. 71104** Ensure deceased individuals do not remain enrolled
- **Sec. 71107** Conduct more frequent renewals for the expansion population
- **Sec. 71112** Reducing state Medicaid costs (Changes to Retroactive Eligibility)
- **Sec. 71119** Establish Medicaid community engagement requirements for certain individuals

**E&E**
**MMIS Claims Processing**
**MMIS Data Warehouse**
**MMIS Financial Management**
**MMIS Member Management** — E&E

**Sec. 71118** Require budget neutrality for 1115 demonstrations

**MMIS Financial Management** — Financing

**10/1/2027**

**Sec. 71115** Provider taxes - Expansion state hold harmless reduction begins

**MMIS Financial Management** — Financing

**1/1/2028**

**Sec. 71105** Ensure deceased providers do not remain enrolled

**MMIS Provider Management** — E&E

**Sec. 71108** Change to home equity limit for determining eligibility for long-term care services

E&E

**Sec. 71116** Start reduction for grandfathered SDPs in Medicaid

**MMIS Financial Management**
**MMIS Data Warehouse** — Financing

**7/1/2028**

**Sec. 71121** Option for states to approve 1915(c) HCBS waiver for individuals that do not meet an institutional level of care

**E&E**
**MMIS Data Warehouse**
**MMIS Financial Management** — E&E

**10/1/2028**

**Sec. 71120** Modify cost sharing requirements for certain expansion individuals under the Medicaid program.

**MMIS Claims Processing**
**MMIS Financial Management**
**MMIS Member Management** — Financing

**Sec. 71120** Modify premium requirements for certain expansion individuals under the Medicaid program.

E&E

**10/1/2029**

**Sec. 71103** Submit data to new system established by the Secretary to reduce duplicate enrollment into Medicaid and CHIP

**E&E**
**MMIS Data Warehouse**
**MMIS Member Management** — E&E

**Sec. 71106** Start of payment reduction related to certain erroneous excess payments under Medicaid.

**MMIS Financial Management** — Financing

## Ensuring Access to Medicaid Services

CMS-2442-F

**For details on enforcement discretion, see the CMCS Informational Bulletin dated December 23, 2025: https://www.medicaid.gov/federal-policy-guidance/downloads/cib12232025.pdf*

***For details on HCBS grievance system enforcement, see the CMCS Informational Bulletin dated February 26, 2026: https://www.medicaid.gov/federal-policy-guidance/downloads/cib02262026.pdf*

**Rule Implementation Applicability Dates**

**7/9/2025**

**Publish on public website** processes and practices for the administration of the MAC and the BAC, including recruitment and selection of members

**Website** — Transparency

**7/1/2026**

**Publish on public website** various FFS payment rates and rate comparative analysis

**Website** — Transparency

**7/9/2026**

Implement a **grievance system for HCBS beneficiaries** to report issues related to the state or providers performance of required waiver activities.**

**MMIS LTSS** — Transparency

**12/31/2026**

- **Begin to implement HCBS Quality Measure Set identified by CMS** and prepare for data collection and reporting
- **Quality assurance and improvement plan requirements**, including reporting requirements relevant to the State's self-directed PAS program

**MMIS LTSS** — Reporting

**7/9/2027**

- Requirements for **performance thresholds and metrics for person-centered service plans**
- Incorporate a continuous quality improvement process that includes **monitoring, remediation, and quality improvement for critical incidents**

**MMIS LTSS** — Quality

Website transparency to **ensure beneficiaries have easy access to comprehensive information**, including the results of the reporting requirements.

**MMIS LTSS** — Transparency

- Report the **results of incident management system assessment** and specific **information about critical incidents**
- Report on **waiver waiting lists**
- Report on **access to homemaker, home health aide, personal care, and habilitation services**

**MMIS LTSS**
**MMIS Data Warehouse** — Reporting

**7/9/2028**

Report on **HCBS Quality Measure Set and payment adequacy** - compensation for direct care workers

**MMIS Data Warehouse**
**MMIS Financial Management** — Reporting

Establish state **performance targets for each of the measures in the HCBS Quality Measure Set** that are identified by the Secretary

**MMIS LTSS** — Quality

**1/9/2029**

**Establish interested parties advisory group** to advise and consult on certain HCBS provider rates for direct care workers.*

**Website** — Transparency

**7/9/2029**

Implement **electronic incident management system** to identify report, triage, investigate, resolve, track, and trend critical incidents

**MMIS LTSS** — Transparency

**7/9/2030**

**HCBS payment adequacy requirements**, including adequate payment rates for direct care workforce

**MMIS Claims Processing** — Service

## Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

CMS-2439-F

**Rule Implementation Applicability Dates**

**7/9/2025**

Provide network adequacy and access assurances within specified timeframes

**MMIS Member Management**
**MMIS Data Warehouse** — Services

Post on the state website:
- The **results of the quality strategy review and evaluation**
- State's assurance of plans **compliance with network adequacy and access requirements**

**Website** — Transparency

**12/31/2025**

Maintain at least the previous **5 years of EQR technical reports on the state website**

**MMIS Member Management**
**Website** — Transparency

**7/9/2026**

- Operate a **website providing direct links** to required documents and reports
- **Continuously verify the accuracy and timeliness** of the website information
- For CHIP, **post comparative summary results** of enrollee experience surveys on the website

**Website** — Transparency

**Collect annual payment analysis** for each managed care plan and include in the network adequacy and access report to CMS

**MMIS Financial Management**
**MMIS Data Warehouse** — Data

For CHIP, use **results of enrollee experience surveys in analysis of access standards**

Services

**7/9/2027**

- If a state uses SDPs in Medicaid
  - **Report final SDP percentage**
  - **Submit evaluation report**, upon CMS request
- **Include results of an enrollee experience survey** in the Medicaid Managed Care Program Annual Report (MCPAR)

**MMIS Data Warehouse** — Reporting

- If state uses SDPs in Medicaid that requires written approval, **include at least 2 metrics to measure effectiveness in evaluation plan**
- Use results from enrollee experience surveys to **improve the performance of its Medicaid managed care program**

Quality

Establish **appointment standards for routine appointments** for specified services

**MMIS Member Management** — Services

**7/10/2028**

**Conduct secret shopper surveys** to monitor plan compliance with provider directory and appointment wait time requirements

**MMIS Member Management** — Transparency

**12/31/2028**

Adopt and implement the **Quality Rating System (QRS) framework** using the MAC QRS methodology developed by CMS or an alternative methodology approved by CMS

**MMIS Member Management** — Quality

**After 2030**

After 2030, CMS has discretion to require the display of quality ratings for MAC QRS measures by several stratification factors.

**MMIS Member Management** — Quality

**MMIS Data Warehouse**
**If state uses SDPs in Medicaid, report total dollar expended to T-MSIS - Applicable by the first rating period beginning on or after the release of reporting instructions**

Reporting

## Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes*

CMS-2421-F2

**Includes "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" final rule (CMS-2421-F)*

***Sections 71101 and 71102 of the WFTC legislation temporarily prohibit CMS from implementing, administering, or enforcing certain amendments made by the provisions of the MSP and E&E final rules that had a compliance date after July 4, 2025. The moratorium on these amendments ends on September 30, 2034.*

**Rule Implementation Applicability Dates**

**6/3/2025**

- Sunset existing **CHIP waiting or premium lock-out periods**
- Remove Requirement to **apply for other benefits**

**E&E** — E&E

Sunset existing **annual and lifetime limits** on CHIP benefits

**CHIP Financial Management** — Services

**6/3/2026**

New **electronic recordkeeping** requirements

**E&E**
**MMIS** — E&E

**9/30/2034**

- Primacy of **electronic verification and reasonable compatibility standard** applied to resource verification
- Agency must take **action on returned mail**
- **Maximize use of LIS "leads" data including**:
  - Treat data as an application for MSP
  - Not require additional verification unless the agency has information not reasonably compatible with data
  - Provide at least 30 days for applicant to provide additional needed information
  - Provide applicant with information about additional Medicaid benefits on other bases
- **Self-attestation of dividend and interest income, burial funds, life insurance and value of non-liquid resources for MSP applicants and spouses, unless the State has information that is not reasonably compatible with the attestation.**
  - May conduct post-eligibility verification
  - Provide at least 90 calendar days to respond to requests for additional information (15 days for life insurance if face value under $1500)
- **Use the Definition of "Family Size" in the Medicare Part D Low-Income Subsidy Program for MSP eligibility**
- Changes to **verification of citizenship and identity**

**E&E** — E&E

## Medicare and Medicaid Programs; Repeal of Minimum Staffing Standards for Long-Term Care Facilities

CMS-3442-IFC

**Rule Implementation Applicability Dates**

**2/2/2026**

LTC facilities are **no longer required to implement** the following for both rural and non-rural facilities:
- facility assessment requirements.
- 3.48 HPRD total nurse staffing requirement and the 24/7 RN requirement.
- 0.55 RN and 2.45 NA HPRD requirements.

42 CFR Part 483 contains the reset requirements.

**MMIS LTSS** — Services

## Centers for Medicare & Medicaid Services' Interoperability and Prior Authorization Final Rule

CMS-0057-F

**Rule Implementation Applicability Dates**

**3/31/2026**

Report metrics in the form of aggregated, de-identified data to CMS on the number of patients who use the Patient Access API. Specifically, this includes:
1. The total number of unique patients whose data are transferred via the Patient Access API to a health app designated by the patient; and
2. The total number of unique patients whose data are transferred more than once via the Patient Access API to a health app designated by the patient.(89 FR 8784).

**MMIS Data Warehouse** — Reporting

**1/1/2027**

Make information available about prior authorization requests and decisions for both Medicaid and CHIP FFS and managed care (excluding drugs) available via the Patient Access API:
- The prior authorization status.
- The date the prior authorization was approved or denied.
- The date or circumstance under which the prior authorization ends.
- The items and services approved.
- If denied, a specific reason why the request was denied.
- Related structured administrative and clinical documentation submitted by a provider.

**MMIS Claims Processing** — Transparency

*January 1, 2027 for state Medicaid and CHIP FFS programs. The rating period beginning on or after January 1, 2027 for Medicaid managed care plans and CHIP managed care entities.*

## Consolidated Appropriations Act, 2024 and 2026

Public Law No. 118-42, March 9, 2024 and Public Law No. 119-75, February 3, 2026

**or under an applicable plan (as defined in section 1862(a)(1)(F)) of the Act, which includes liability insurance, no fault insurance, and workers compensation.*

**Rule Implementation Applicability Dates**

**3/10/2025***

States with the IMD state plan option must commence an assessment of the availability of treatment for individuals enrolled in Medicaid in each of the required levels of care across the care continuum as well as the availability of MAT and medically supervised withdrawal management services and complete such assessment within 12 months.

Quality

**or not later than 12 months after approval of a state plan amendment*

**10/2025**

States with the IMD state plan option are required to have in place evidence-based, SUD-specific individual placement criteria and utilization management approaches.

Quality

**1/2026**

States are required to suspend rather than terminate Medicaid or CHIP coverage for individuals who are inmates of public institution.

**E&E**
**MMIS Claims Processing** — E&E

**2/3/2026**

No longer apply an upper age limit of 65+ for states that newly adopt option to cover Ticket to Work Basic group or Ticket to Work Medical Improvement group

**E&E** — E&E

- Modifies the DSH payment methodology to allow hospitals to include unreimbursed costs for patients who are dually eligible for both Medicare and Medicaid* towards their Medicaid shortfall calculation when the hospital's aggregate costs exceed the payments for this population
- For rate years beginning on or after October 1, 2022, states with unspent DSH allotments from prior years (on or after 10/1/21) have the option to increase the amount of payment to a hospital for such rate year up to the new, modified cap and to retroactively modify SPAs to allow for this payment adjustment
- Prohibit states from recouping any DSH payment already made to a hospital for a previous rate year provided the payment is consistent with the methodology in effect prior to the statutory updates made under the CAA 2026.
- States must report these changes on a revised annual report, in accordance with section 1923(j)(1), applicable to the rate year for which the payment is being made.

**MMIS Claims Processing**
**MMIS Financial Management** — Financing

**3/10/2026**

States are required to have in place a program to monitor and manage the appropriate use of antipsychotic medications among individuals over the age of 18 receiving HCBS or residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings).

**MMIS PBM** — Quality

**1/1/2028**

States with existing SPAs must remove the upper age limit (65+) for: Ticket to Work Basic group and Ticket to Work Medical Improvement group

**E&E** — E&E

**8/3/2028**

States must complete and submit to HHS a study on the costs of providing maternity, labor, and delivery services in applicable hospitals
- Studies must include comparative analysis for Medicaid, Medicare, and private health insurance
- States must complete and submit a report to HHS every 5 years

**MMIS Financial Management**
**MMIS Data Warehouse** — Services

**1/3/2029**

Establish a streamlined process to pay eligible out-of-state providers for providing services to an individual under 21 years of age enrolled under the State Plan or waiver
- Allow eligible out-of-state providers remain enrolled for a 5-year period unless otherwise terminated

**MMIS Claims Processing**
**MMIS Provider Management** — Services

**1/1/2030**

States to treat certain active-duty military members and dependents as state residents for Medicaid
- Pay for covered services furnished in another state
- Allow individuals to remain on HCBS waiting lists after relocation

**E&E**
**MMIS Claims Processing**
**MMIS LTSS** — E&E

*Notes:*

- *Actual reporting and implementation deadlines will vary by provision.*
- *Applicability dates for CMS-2439-F (in addition to other select statutes and final rule provisions) generally begin on or after the next rating period following the applicability date.*
- *This timeline is current as of April 2026. It will be reviewed and updated periodically to reflect any changes or new developments. States are encouraged to refer to the most recent version to ensure they have the latest information.*