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.

Rules

Statutes

2025

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

Managed Care
- Provide network adequacy and access assurances within specified timeframes
- 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
- Maintain at least the previous 5 years of EQR technical reports on the state website

E&E/MSP
- Sunset existing CHIP waiting or premium lock-out periods
- Remove Requirement to apply for other benefits
- Sunset existing annual and lifetime limits on CHIP benefits

CAA, 2024
- States with the IMD state plan option must:
  - Commence assessment of the availability of treatment across the care continuum for individuals enrolled in Medicaid
  - Have in place evidence-based, SUD-specific individual placement criteria and utilization management approaches

WFTC Legislation[2]
- 71101: Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs
- 71102: Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program
- 71111: Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.
- 71113: Federal payments to prohibited entities
- 71116: New provider payment rate limit for applicable SDPs in Medicaid
- 71117: Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax
- 71401: Rural Health Transformation Program[1]

2026

Access
- Publish on public website FFS rates
- Implement HCBS grievance system, Quality Measure Set, and quality assurance and improvement plan[4]⚠

Managed Care
- Operate a website with direct links and continually verify accuracy
- For CHIP post comparative summary results of enrollee surveys
- Collect and report annual plan payment analysis
- For CHIP include enrollee survey results in analysis of access

E&E/MSP
- New electronic recordkeeping requirements

Repeal of Minimum Staffing Standards
- Repeal of LTC staffing standards

Interoperability
- Report metrics on use of the Patient Access API metrics to CMS

CAA, 2024
- Suspend rather than terminate coverage for inmates
- Implement program to monitor/manage use of antipsychotic medications for individuals over age 18 receiving HCBS or residing in institutional care settings

CAA, 2026
- No longer apply an upper age limit of 65+ for states that newly adopt the option to cover Ticket to Work Basic group or Ticket to Work Medical Improvement group
- Modifies DSH payment adjustment formula

WFTC Legislation[2]
- 71109: Changes to FFP and eligibility for noncitizens in Medicaid and CHIP
- 71110: Expansion FMAP for emergency Medicaid
- 71114: Sunsetting Increased FMAP Incentive
- 71115: Provider Taxes - Change in threshold for hold harmless provision

2027

Access
- Person-centered service plan performance metrics
- Incorporate a continuous quality improvement process
- Website transparency for beneficiaries
- Reporting on results of incident management system and critical incidents, waiver waiting lists and access to specific services

Managed Care
- Include results of Medicaid enrollee experience survey in MCPAR
- Report final SDP percentages in Medicaid and submit evaluation report to CMS
- Include metrics to measure effectiveness in evaluation plan for SDPs in Medicaid that require written approval
- Use Medicaid enrollee surveys to improve the performance of its managed care program
- Establish appointment standards for routine appointments

Interoperability
- Make information available about prior authorization requests and decisions for Medicaid and CHIP FFS and managed care

WFTC Legislation[2]
- 71103: Concurrent enrollment (address verification)
- 71104: Removing deceased individuals
- 71107: Eligibility redeterminations
- 71112: Reducing State Medicaid Costs (Changes to Retroactive Eligibility)
- 71115: Provider Taxes - Expansion state hold harmless reduction begins
- 71118: Budget neutrality
- 71119: Community engagement[1]

2028

Access
- HCBS Quality Measure Set and payment adequacy report
- Establish performance targets for each HCBS Quality Measure Set measure

Managed Care
- Conduct secret shopper surveys to monitor plan compliance
- Adopt and implement the Quality Rating System (QRS) framework
- Display quality ratings on public website

CAA, 2026
- For existing coverage, remove the upper age limit (65+) for Ticket to Work Basic group and Ticket to Work Medical Improvement group
- States must submit a study on the costs of providing maternity, labor, and delivery services in applicable hospitals

WFTC Legislation[2]
- 71105: Removing deceased providers
- 71108: Home equity
- 71116: Start reduction for grandfathered SDPs in Medicaid
- 71120: Cost sharing
- 71121: New HCBS Waiver Option[1]

2029

Access
- Implement electronic incident management system
- Establish interested parties advisory group[3]⚠

CAA, 2026
- Establish a streamlined process to pay eligible out-of-state pediatric providers

WFTC Legislation[2]
- 71103: Concurrent enrollment (new system)
- 71106: Payment reduction - erroneous payments

2030

Access
- HCBS payment adequacy requirements

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

CAA, 2026
- States to treat certain active-duty military members and dependents receiving HCBS as state residents for Medicaid[1]

Footnotes:

[1] State funding appropriated

[2] For details on specific provisions included in Public Law 119-21, which CMS refers to as the "Working Families Tax Cut" (WFTC) legislation, see the Nov 18, 2025 CMCS informational Bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf

⚠[3] For details on enforcement discretion, see the Dec 23, 2025 CMCS Informational Bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/cib12232025.pdf

⚠[4] For details on HCBS grievance system enforcement, see the Feb. 26, 2026 CMCS Informational Bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/cib02262026.pdf

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.*