DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

September 30, 2025

Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority
1225 "Eye" Street, NW, 4th floor
Washington, DC 20005

Dear Executive Director Kofman:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved the District of Columbia's (DC) Basic Health Program (BHP) Blueprint, submitted on August 29, 2025. This certified Blueprint permits DC to establish a BHP and received federal funds in its BHP trust fund, with coverage beginning January 1, 2026.

The BHP Blueprint contains sufficient information to determine that the BHP will comply with the requirements of section 1331 of the Affordable Care Act (ACA) and 42 CFR Part 600. The Blueprint demonstrates adequate planning for the integration of BHP with other insurance affordability programs in a manner that will permit a seamless, coordinated experience for potentially eligible individuals seeking coverage in any of the programs. The Blueprint is also a complete and comprehensive description of the BHP and its operations, demonstrating thorough planning and a concrete program design.

As you know, DC plans to redetermine eligibility for residents currently covered by Medicaid, specifically parents/caretakers and other adults with household incomes above 133 percent federal poverty level (FPL), who will no longer qualify for Medicaid due to Medicaid eligibility changes in alignment with DC's BHP. The DC Medicaid eligibility changes are currently under review by CMS through the DC Medicaid State Plan Amendment (SPA) DC-25-0013.

Your BHP Project Officer is Carrie Grubert. She is available to answer your questions concerning BHP-related matters and can be reached at Carrie.Grubert@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Alice Weiss/

Alice Weiss
Acting Director
on Behalf of Sarah deLone, Director

Basic Health Program Blueprint

Introduction

Section 1331(a) of the Affordable Care Act directs the Secretary to establish a Basic Health Program (BHP) that provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage.

States choosing to operate a BHP must submit this BHP Blueprint as an official request for certification of the program.

States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace. A state that operates a BHP will receive federal funding equal to 95 percent of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals, using a methodology set forth in a separate funding protocol based on a methodology set forth in companion rulemaking.

Given the population served under BHP, the program will sit between Medicaid and the Marketplace, and while states will have significant flexibility in how to establish a BHP, the program must fit within this broader construct and be coordinated with other insurance affordability programs. Regulations for the BHP were finalized on March 12, 2014 and are available at https://www.medicaid.gov/basic-health-program/index.html.

The BHP Blueprint is intended to collect the design choices of the state and ensure that we have a full understanding of the operations and management of the program and its compliance with the federal rules; it is not intended to duplicate information that we have collected through state applications for other insurance affordability programs. In the event that a State seeks to make a significant change(s) that alter program operations described in the certified Blueprint, the state must submit a revised Blueprint to the Secretary for review and certification.

The BHP Blueprint sections reflect the final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and Secretarial oversight relating to BHP.

Acronyms List

BHP	Basic Health Program
CHIP	Children's Health Insurance Program
CSR	Cost Sharing Reduction
ESI	Employer Sponsored Insurance
EHB	Essential Health Benefits
FPL	Federal Poverty Level
IAP	Insurance Affordability Program
MEC	Minimum Essential Coverage
OMB	Office of Management and Budget
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SHP	Standard Health Plan

Section 1: Basic Health Program-State Background Information

State Name: District of Columbia

Program Name (if different than Basic Health Program): Healthy DC Plan

BHP Blueprint Designated State Contact:

Name: Bonnie Norton
Title: Deputy Director of Program Services
Phone: 202-262-8325
Email: bonnie.norton@dc.gov

Requested Initial Interim Certification Date (if applicable): N/A

Requested Initial Full Certification Date: 10/1/2025

Requested Initial Program Effective Date: 1/1/2026

Blueprint Revisions:

Revision number	Summary	Effective date	Certification date
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Administrative agency responsible for BHP ("BHP Administering Agency"):

DC Health Benefit Exchange Authority (DCHBX).

BHP State Administrative Officers:

Position	Title	Location (Agency)	Responsible for:
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Program Administration: (Management, Policy, Oversight)

Position	Title	Location (Agency)	Responsible for:
Bonnie Norton	Deputy Director of Program Services	DCHBX	Management, policy, and oversight.
Alex Alonso	Deputy General Counsel and Policy Advisor	DCHBX	Legal and oversight
Enter text.	Enter text.	Enter text.	Enter text.

Program Administration: (Contracting, Eligibility Appeals, Coverage Appeals)

Position	Title	Location (Agency)	Responsible for:
Katie Nicol	Deputy Director, Health Coverage & Innovation	DCHBX	Management of eligibility and enrollment
Erica Deray	Assistant Director of the Individual Market	DCHBX	Eligibility and verification operations, appeals
Alex Alonso	Deputy General Counsel and Policy Advisor	DCHBX	Legal, appeals and carrier contracts

Finance: (Budget, Payments)

Position	Title	Location (Agency)	Responsible for:
Marjorie Edmonds	Agency Chief Financial Officer	DCHBX	Financial Operations
Bonnie Norton	Deputy Director of Program Services	DCHBX	Budget
Ellen O'Brien	Senior Policy Advisor, Health Coverage and Innovation	DCHBX	Forecasting and data analysis
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Governor or Designee:
Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority

Signature:
/Signed by Mila Kofman/

Date of Official Submission: August 29, 2025

Section 2: Public Input

This section of the Blueprint records the state's method for meeting the public comment process required for Blueprint submission. This section applies only to the current Blueprint submission.

Date public comment period opened: June 17, 2025
Date public comment period closed: July 16, 2025

Please describe the public comment process used in your state, such as public meetings, legislative sessions/hearing, the use of electronic listservs, etc.:

DC Health Benefit Exchange Authority (DCHBX) established a Basic Health Plan Advisory Council to receive input on the establishment and implementation of BHP. This is consistent with the stakeholder working group model used by the DCHBX in the establishment and operations of the District's on-line health insurance marketplace, DC Health Link. The BHP Advisory Council includes insurers, physicians, hospitals, consumer and patient advocates, faith-based organizations, policy experts and trusted voices from the community where BHP enrollees reside (find a full list below). The group is chaired by a former DC Medicaid Director and vice-chaired by the vice-chair of the DCHBX Standing Advisory Board. The weekly meetings began June 2, 2025 and are open to the public.

At the BHP Advisory Council meeting on June 9, 2025 DCHBX reviewed key components of the draft Basic Health Plan Blueprint, answered questions and sought feedback. DCHBX also sent the written draft Blueprint to Advisory Council members the same day of the briefing and requested additional feedback.

DCHBX considered and integrated feedback from Advisory Council members and posted an updated draft Blueprint to its website (https://hbx.dc.gov/page/basic-health-plan) on June 17, 2025 with a 30-day comment period that ended July 16, 2025. After the close of the comment period, DCHBX considered and integrated feedback for the Blueprint submission to CMS.

The Basic Health Plan Advisory Council includes: Pennsylvania Baptist Church, Ward 7 Faith Leaders, Mayor's Interfaith Council, MDP Faith Advisory Council; Fellowship Bible Church, Wednesday Clergy Fellowship, Leadership Council for Healthy Families; Union Temple Baptist Church; DC Fiscal Policy Institute; DC Primary Care Association; Whitman Walker Health; Health Alliance Network, Ward 8 Health & Wellness Council; Far Southeast Family Strengthening Collaborative; Anacostia Economic Development Corporation; William O. Lockridge Community Foundation; DC Health Link Hispanic Advisory Council; DC Action; Medical Society of the District of Columbia; DC Behavioral Health Association; Legal Aid Society of the District of Columbia; Kaiser Permanente; and Medstar Family Choice.

Provide a list below of the groups/individuals that provided public comment:

Bread for the City; CareFirst BlueCross BlueShield; DC Behavioral Health Association; DC Fiscal Policy Institute; DC Kincare Alliance; DC Primary Care Association; La Clinica del Pueblo; Legal Aid Society of DC; National Health Law Program; Whitman Walker Health; and Vice-Chair of BHP Advisory Council

If the state has federally recognized tribes, list them below. Provide an assurance that they were included in public comment and note if comments were received.

Federally recognized tribe	State agency solicited input (Indicate with an "X" if input was solicited)	Input received (Indicate with an "X" if input was solicited)

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Provide a brief summary of public comments received and the changes made, if any, in response to public comments:

In addition to the feedback received from our BHP Advisory Council, DCHBX received public comments. Common themes from the written comments included: support for the establishing a BHP; support for continuity of coverage and continuity of care goals and a seamless transition between Medicaid and BHP for the initial BHP eligible population and on an ongoing basis; concerns about the proposed one year transition and instead advocating for a Medicaid-type year-round enrollment; advocating for a new SEP; support for no cost sharing or limited cost sharing; support for aligning provider networks and payment rates across the BHP and Medicaid; concerns about basing BHP coverage on commercial benefits and instead advocating for expanding the benefits to align with the current Medicaid benefit package, specifically covering dental services, vision services, non-emergency medical transportation, and behavioral health services not covered in EHB; advocating for allowing enrollees auto-enrolled into a BHP plan to have an option to change plans; and advocating for expansion of eligibility for BHP beyond federal eligibility level.

DCHBX clarified the Blueprint based on questions about DCHBX's proposed approach. DCHBX did not adopt requests to include non-Medicaid benefits, change eligibility (which is a federal requirement), or to adopt Medicaid eligibility and enrollment rules.

For operational, technical, and policy reasons, DCHBX did not change its approach. DCHBX will leverage its Exchange private health insurance marketplace standards for the BHP, including an annual open enrollment period and special enrollment periods. DCHBX clarified that only for our first year (2026), for administrative simplicity and to mitigate potential consumer confusion or any other friction, after open enrollment ends residents will continue to be allowed to enroll in the BHP without a special enrollment period. This is the same as Medicaid, which is year-round. In our case, we would allow year round enrollment only in 2026. We will use private market rules for eligibility and coverage will be based on calendar year. If a resident enrolls in June, coverage will end in December just like private health insurance. We will redetermine eligibility in October and will renew coverage assuming that the resident is eligible. Additionally, we will use private market rules for periodic data-matching including for death, Medicare, and Medicaid enrollment.

Section 3: Trust Fund

Please provide the BHP Trust Fund location and relevant account information.

Institution:

Wells Fargo Bank, N.A.

Address:

P.O. Box 63020, San Francisco, California 94163

Phone Number:

800-298-3557

Account Name:

Government of the District of Columbia – HBX BHP Trust Fund Account

Account Number:

Click or tap here to enter text.

Trustees

Name	Organization	Title	May authorize withdrawals? (Indicate with an "X" if named individual can authorize withdrawals)
Bonnie Norton	DC Health Benefit Exchange Authority	Deputy Director of Program Services	☒
Mila Kofman	DC Health Benefit Exchange Authority	Executive Director	☒
Purvee Kempf	DC Health Benefit Exchange Authority	Deputy Executive Director	☒
Eliza Bangit	DC Health Benefit Exchange Authority	Senior Advisor and Director of Health Coverage and Innovation	☒
Yi-Ru Chen	DC Health Benefit Exchange Authority	Senior Director for Programs and Operations	☒

Is anyone other than Trustees indicated above able to authorize withdrawals?

No.

If yes, please include the name and title of everyone with this authority.

Name	Organization	Title
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If there is separation between the entity holding the trust fund ("Trustees") and the entity operating the trust fund, please describe the relationship below. Include the name, and contacts for the entity operating the trust fund. Also include a copy of a written agreement outlining the responsibilities of the entity operating the trust fund.

Name	Organization	Title	Contact
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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Please name the CMS primary contact for the BHP trust fund and provide contact information.
CMS Primary Contact Name: Click or tap here to enter text.
CMS Primary Contact Phone: Click or tap here to enter text.
CMS Primary Contact Email: Click or tap here to enter text.

Please describe the process of appointing trustees:

The named appointees are assigned as trustees on the basis of their current positions within DCHBX. Based on existing procedures and the way the DCHBX oversees all financials, including federal funds, the appropriate lead fiscal representatives were named as Trustees for the BHP Trust Fund. This allows the DCHBX to follow the same procedures, review and oversight as is conducted for other state related business.

Provide a list of all responsibilities of Trustees:

The Trustees are assigned based on their current positions within DCHBX. Trustees are responsible for the direction, budget, and operations of DCHBX, which is responsible for DC Health Link, the online health insurance marketplace, or specifically responsible for the management and operations of the BHP within the agency. Therefore, all Trustees listed have significant financial responsibility within the District and have the qualifications to make decisions related to this matter. Trustees provide oversight to ensure that all fund expenditures are made in an allowable manner. In addition, Trustees will specify individuals with authority to make withdrawals from the trust fund to make allowable expenditures.

Has the state made any arrangements to insure or indemnify trustees against claims for breaches of fiduciary responsibility?

Yes.

If yes, what are they?

DCHBX has included indemnification language in all vendor and carrier agreements for vendor or carrier negligence. In addition, the District's Settlement and Judgement Fund, which is available for the payment of settlements and judgments incurred by the District government, can insure or indemnify all District employees for official activities.

Trust Fund Attestation	**Attest that the Agency is immediately ready and able.** (Indicate with an "X" to signal attestation.)	**Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)**
The BHP Administering Agency will:		
600.710(a) Maintain an accounting system and fiscal records in compliance with Federal requirements for state grantees, including OMB circulars A-87 and A-133 and applicable federal regulations.	☒	Click or tap to enter a date.
600.710(b) Obtain an annual certification from the BHP Trustees, the State's CFO, or designee, certifying the state's BHP Trust Fund FY financial statements, and certifying that BHP trust funds are not being used for the non-federal share for any Federally funded program, and that the use of BHP trust funds is otherwise in accordance with Federal requirements (including that use of BHP funds is limited to permissible purposes).	☒	Click or tap to enter a date.
600.710(c) Conduct an independent audit of Trust Fund expenditures over a 3-year period in accordance with chapter 3 of GAO's Government Auditing Standards.	☒	Click or tap to enter a date.
600.710(d) Publish annual reports on the use of funds within 10 days of approval by the trustees.	☒	Click or tap to enter a date.
600.710(e) Establish and maintain BHP Trust Fund restitution procedures.	☒	Click or tap to enter a date.
600.710(f) and (g) Retain records for 3 years from the date of submission of a final expenditure report or until the resolution and final actions are completed on any claims, audit or litigation involving the records.	☒	Click or tap to enter a date.

Section 4: Eligibility & Enrollment

This section of the Blueprint records the state's choices in determining eligibility procedures for BHP and records assurances that demonstrate comportment with BHP standards. The state must check all pertinent boxes and fill in dates where applicable.

Please name the agency with primary responsibility for the function of performing eligibility determinations:

Attestation	**Completed** (Indicate with an "X" to signal completion)	**If No, Expected Completion Date (mm/dd/yyyy)**	**Marketplace Policy** (Indicate with an "X" if Marketplace Policy applies)	**Medicaid Policy** (Indicate with an "X" if Medicaid Policy applies)
Eligibility Standards				
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.	☐	11/1/2025	N/A	N/A
305(a)(1) Resident of the State.	N/A	N/A	N/A	N/A
305(a)(2) Citizen with household income exceeding 133 but not exceeding 200% FPL or lawfully present non-citizen ineligible for Medicaid or CHIP due to immigration status with household income below 200% FPL.	N/A	N/A	N/A	N/A
305(a)(3) Not eligible to enroll in MEC or affordable ESI.	N/A	N/A	N/A	N/A
305(a)(4) Less than 65 years old.	N/A	N/A	N/A	N/A
305(a)(6) Not incarcerated other than during disposition of charges.	N/A	N/A	N/A	N/A
Application Activities				
310(a) Single streamlined application includes relevant BHP information.	☐	11/1/2025	N/A	N/A
310(b) Application assistance, including being accessible to persons who are limited English proficient and persons who have disabilities consistent with 42 CFR435.905(b), is equal to Medicaid.	☒		N/A	N/A
310(c) State is permitting authorized representatives; indicate which standards will be used.	☒	Click or tap to enter a date.	☒	☐
315 State is using certified application counselors; indicate which standards will be used.	☒	Click or tap to enter a date.	☒	☐

Attestation	Completed (Indicate with an "X" to signal completion)	If No, Expected Completion Date (mm/dd/yyyy)	Marketplace Policy (Indicate with an "X" if Marketplace Policy applies)	Medicaid Policy (Indicate with an "X" if Medicaid Policy applies)
Eligibility Determinations and Enrollment				
320(c) Indicate the standard used to determine the effective date for eligibility.	☐	11/1/2025	☒	☐
320(d) Indicate the enrollment policy used in BHP (the open and special enrollment periods of the Exchange OR the continuous enrollment process of Medicaid).	☐	11/1/2025	☒ Effective January 1, 2027	☒ Effective January 1, 2026
335(b) Indicate the standard used for applicants to appeal an eligibility determination.	☒		☒	☐
340(c) Indicate the standard used to redetermine BHP eligibility.	☐	11/1/2025	☒	☐
345 Indicate the standard to verify the eligibility of applicants for BHP.	☐	11/1/2025	☒	☐

Note: N/A = Not applicable; indicates that there are no choices available.

1. Please indicate whether the state will implement continuous eligibility and redetermine enrollees every 12 months as long as enrollees are under 65, not enrolled in alternative MEC and remain state residents.

   No.

   If no, please explain redetermination standards. (These standards must be in compliance with 42 CFR 600.340(f).)

The DC Health Benefit Exchange Authority (DCHBX) is currently responsible for more than $650 million in annual premiums and is responsible for safeguarding millions of federal taxpayer dollars. To ensure that only qualified residents are able to enroll and stay enrolled, DCHBX will use current Marketplace eligibility standards established by CCIIO through regulatory guidance. If those standards are changed legislatively or through regulations, DCHBX will update initial, on-going, and renewal eligibility standards in conformity with the new standards. DCHBX will redetermine eligibility annually before open enrollment begins consistent with Exchange private health insurance marketplace rules. In other words, in some cases, there will not be a 12-month long coverage period. When a qualified resident enrolls mid-year, coverage will end December 31 of that year. If the resident remains eligible when annual pre-open enrollment eligibility is checked, that resident's coverage will be renewed for the following calendar year. This standard applies to QHPs and will apply to BHP coverage. In addition to undergoing annual redetermination, enrollees are required to report changes in circumstance within 30 days in accordance with 45 CFR § 155.330. Reported changes in circumstance will trigger eligibility redeterminations. Additionally, DCHBX will conduct periodic eligibility checks, similar to checks conducted for those with Advanced Premium Tax Credits (APTCs) enrolled in Qualified Health Plans (QHPs), as required in 45 CFR § 155.330(d), which includes checking for death, Medicare, and Medicaid. For renewals, DCHBX will use the Marketplace redetermination and verification processes in accordance with 45 CFR § 155.335. Separately, DCHBX will use private health insurance standards for enrollment. This means that the annual open enrollment period applicable to QHP enrollment will apply to BHP enrollment. For administrative simplicity, to mitigate potential consumer confusion or any other friction in 2026, after open enrollment ends residents will be allowed to enroll. This is the same as Medicaid, which is year-round. In our case, we would allow year round enrollment only in 2026. This approach is also needed to help us be most efficient with our operational resources as we implement legislative and regulatory changes applicable to state-based marketplaces.

2. Please list the standards established by the state to ensure timely eligibility determinations. (These standards must be in compliance with 42 CFR 435.912 exclusive of 435.912(c)(3)(i)).

DCHBX is responsible for DC Health Link, the on-line health insurance marketplace. DCHBX conducts real-time eligibility determinations for APTCs and Cost Sharing Reductions (CSRs, as well as determining eligibility to enroll in QHP with full premium (no APTCs or CSRs). DCHBX will use its existing eligibility determinations process to determine eligibility for BHP. If a real-time determination is not possible, for example, if there is a system delay or the submission of a paper application, DCHBX policy requires a determination to be made as soon as practicable, but within no later than 45 days. Additionally, when CCIIO updates its regulations or eligibility standards are changed legislatively, DCHBX will implement new standards for determining eligibility for BHP by updating its IT system and operational support in conformity with CCIIO standards.

3. Please describe the state's process and timeline for incorporating BHP into the eligibility service in the state including the State's Marketplace (if applicable). Include pertinent time-frames and any contingencies that will be used until system changes (if necessary) can be made.

DCHBX is responsible for DC Health Link, the on-line health insurance marketplace. DCHBX conducts real-time eligibility determinations for APTCs and CSRs, as well as eligibility to enroll in QHP with full premium (no APTCs or CSRs). For expedient and efficient use of resources, DCHBX is leveraging the current DC Health Link infrastructure and adding BHP eligibility determinations. This will be completed by October 1, 2025, to accept applications beginning November 1, 2025 for coverage effective January 1, 2026. October 1, 2025 is our code freeze. We do not do major IT deployments while in code freeze for open enrollment for residents, open season for our Congressional enrollees, and our heaviest renewal months of December and January for the over 5,300 District businesses we serve. We are on track to meet the October 1 code freeze deadline.

DCHBX has a record of success. Although we were the last to start building our IT system, we were 1 of 4 state-based exchanges to open for business on time and stay open on October 1, 2013. In 2013 we were designated as a source of coverage for Congressional enrollees including employees in Congressional District offices. In 2017, the Massachusetts exchange chose DCHBX to replace their IT for their small group exchange and to provide operational support. We implemented that on time and on budget. Most recently in 2022, we designed and implemented a private health insurance affordability program for early child development employers and workers in a few months. As a private-public partnership, we have a record of success in designing and implementing initiatives levering our IT and expanding commercial coverage.

4. Please describe the process the state is using to coordinate BHP eligibility and enrollment with other IAPs in such a manner as to ensure seamlessness to applicants and enrollees.

Our goal is to ensure continuity of coverage and continuity of care for individuals who are transitioning between Medicaid, BHP and QHP.

DC Medicaid and DCHBX have coordinated eligibility systems to ensure a seamless transition for individuals between public and private health coverage. The DCHBX system safeguards federal taxpayer dollars by precluding enrollment in private health insurance with APTC when a resident is eligible for or enrolled in Medicaid. These safeguards will be applied to eligibility for BHP to preclude double-dipping and ensure that residents get enrolled only when they qualify and only into coverage for which they qualify. DCHBX will conduct eligibility determinations for BHP and QHP, including PTC and CSR coverage, and assesses eligibility for Medicaid. When the application is assessed for Medicaid eligibility, DCHBX transmits the application via a secure electronic interface and all information provided on the application to DC Medicaid in daily batch files.

For each individual who submits an application or renewal to the DC Medicaid agency that is determined not eligible for Medicaid, but eligible for QHPs, APTCs, CSRs, or BHP, the application is transferred via a secure electronic interface in daily batch files to DCHBX for enrollment.

For residents currently covered by DC Medicaid – childless adults and caregivers with household incomes above 133%FPL -- who will no longer qualify due to eligibility changes – DCHBX is working with Medicaid to extract data in a batch process on these individuals. This will be ingested into our DC Health Link eligibility system no later than September. The process we are using to move approximately 25,000 people from Medicaid to private coverage is a similar process that state exchanges use when they move enrollees from the FFE platform.

Once the data is in DC Health Link, DCHBX will redetermine eligibility for this population. DCHBX will maintain continuity of coverage and care by keeping people enrolled in the same Medicaid Managed Care Organization (MCO) as they were when Medicaid eligible for MCOs that choose to participate in the BHP. Those who are determined to be QHP eligible will have the opportunity to enroll in a QHP.

DCHBX is using standards applicable to private health insurance. Therefore, an exception from using Medicaid standard for appeals of eligibility is necessary to allow DCHBX to use the Exchange private health insurance marketplace standard for applicants to appeal an eligibility determination. DCHBX has a robust internal review process with multiple internal checks that include requesting information and documentation as needed for the review. As a result, very few cases are escalated. However, individuals can appeal eligibility determinations to the DC Office of Administrative Hearings, where an independent administrative law judge makes a final eligibility determination.

Appeals related to the delay, denial, reduction, suspension or termination of healthcare services by the plan are handled consistent with federal requirements for states to have an internal and external review process for private health insurance coverage denials. The DC Department of Insurance, Securities, and Banking (DISB) coordinates with the DC Office of the Health Care Ombudsman and Bill of Rights to support an independent external review.

5. If the state is submitting a transition plan in accordance with 600.305(b), please describe the transition plan in the box below. The plan must include dates by which the state intends to complete transition processes and convert to full implementation.

N/A

Section 5: Standard Health Plan Contracting

This portion of the Blueprint collects information about the service delivery system that will be used in the state as well as how the state plans to contract within that system.

Delivery Systems

1. Please assure that standard health plans from at least two offerors are available to enrollees. ☒

2. If applicable, please describe any additional activities the state will use to further ensure choice of standard health plans to BHP enrollees.

DCHBX is leveraging our successful private market model, where all qualified carriers are invited to participate as long as they meet BHP requirements. Open participation brings more choices, better choices, and more competition.

Additionally, we are working closely with the Department of Insurance Securities and Banking (DISB) to reduce regulatory barriers to entry. For administrative simplicity, DCHBX is using its existing exchange marketplace carrier contract, removing requirements that only apply to QHPs and adding requirements in federal law applicable to BHP. Also, DCHBX is working with DISB to develop "pre-approved" model forms for carriers to use. This will reduce regulatory barriers to participation.

DCHBX established two technical carrier working groups to support carrier participation in the District's Basic Health Plan. We invited all current MCOs and licensed health maintenance organizations (HMOs) in the District. The process and IT working groups started weekly meetings on June 2, 2025, with participants from all three current MCOs and both current licensed HMOs that participate in the exchange individual marketplace. The District has a single service area.

3. If the state is not able to assure choice of at least two standard health plan offerors as described in question 1, please attach the state's exception request. This exception request must include a justification as to why it cannot assure choice of standard health plan offeror and demonstrate that it has reviewed its competitive contracting process in accordance with 42 CFR 600.420(a)(i) - (iii).

N/A

4. Is the state participating in a regional compact?

No.

IF YES, please answer questions 5 - 9. If no, please skip questions 5 - 9.

5. Please indicate the other states participating in the regional compact.

Click or tap here to enter text.

6. Are there specific areas within the participating states that the standard health plans will operate? If yes, please describe.

Click or tap here to enter text.

7. If a state contracts for the provision of geographically specific standard health plans, please describe how it will assure that enrollees, regardless of location within the state, have choice of at least two standard health plan offerors. Please indicate plans by area.

Click or tap here to enter text.

8. Please assure that the regional compact's competitive contracting process complies with the requirements set forth in 42 CFR 600.410. ☐

9. If applicable, please indicate any variations in benefits, premiums and cost sharing, and contracting requirements that may occur as a result of regional differences between the participating regional compact states.

Click or tap here to enter text.

Contracting Process

States must respond to all of the following assurances. If the state has requested an exception to the competitive process for 2015, the State is providing the following assurances with regard to how it will conduct contracting beginning in program year 2016.

The State assures that it has or will:

(These are mandatory elements. Each box below must be checked to approve Blueprint.)

	Assurance: (Indicate with an "X" to signal assurance)
Conducted the contracting process in a manner providing full and open competition including:	
45 CFR 92.36(b) Following its own procurement standards in conformance with applicable federal law.	☒
45 CFR 92.36(c) Conducting the procurement in a manner providing full and open competition.	☒
45 CFR 92.36(d) Using permitted methods of procurement.	☒
45 CFR 92.36(e) Contracting with small, minority and women owned firms to the greatest extent possible.	☒
45 CFR 92.36(f) Providing a cost or price analysis in connection with every procurement action.	☒
45 CFR 92.36(g) Making available the Technical specifications for review.	☒
45 CFR 92.36(h) Following policies for minimum bonding requirements.	☒
45 CFR 92.36(i) Including all the required contract terms in all executed contracts.	☒
Included a negotiation of the following elements:	
Premiums and cost sharing.	☒
Benefits.	☒
Innovative features, such as:	
– Care coordination and care management	☒
– Incentives for the use of preventive services	☒
– Maximization of patient involvement in health care decision making	☒
– Other (specify below) Click or tap here to enter text.	☐
Meeting health care needs of enrollees.	☒
Included criteria in the competitive process to ensure:	
Local availability of and access to providers to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area so that access to services is at least sufficient to meet the standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235.	☒

	Assurance: (Indicate with an "X" to signal assurance)
Use of managed care or a similar process to improve the quality accessibility, appropriate utilization and efficiency of services provided to enrollees.	☒
Development and use of performance measures and standards.	☒
Coordination between other Insurance Affordability Programs.	☒
Measures to address fraud, waste and abuse and ensure consumer protections.	☒
Established protections against discrimination including:	
Safeguards against any enrollment discrimination based on pre-existing condition, other health status related factors, and comply with the nondiscrimination standards set forth at 42 CFR 600.165.	☒
Established a Medical Loss Ratio of at least 85% for any participating health insurance issuer.	
The minimum standard is reflected in contracts	☒

Standard Health Plan Contracting Requirements

States are required to include the standard set of contract requirements that will be incorporated into its Standard Health Plan contracts. Please reproduce in the text box below. Standard Health Plan contracts are required to include contract provisions addressing network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, and provisions protecting the privacy and security of personally identifiable information. However, we have given states a "safe harbor" option of reusing either approved Medicaid or Exchange contracting standards. If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

Although our regular contracting and procurement policies and practices comply with these assurances, we are not using a competitive solicitation RFP process for BHP standard health plans. An exchange commercial market QHP approach will be used and Exchange contracting standards will be used. DCHBX is leveraging our successful private market model, where all qualified carriers can participate as BHP standard health plans. Open participation brings more choices, better choices, and more competition.

Coordination of Health Care Services

Please describe how the state will ensure coordination for the provision of health care services to promote enrollee continuity of care between BHP and Medicaid, CHIP, the Exchange and any other state administered health insurance programs.

Our goal is to ensure continuity of coverage and continuity of care for individuals who are transitioning between Medicaid, BHP and QHP.

For continuity of healthcare services for enrollees moving between Medicaid, BHP, and the QHP, DCHBX is inviting the same managed care plans that serve Medicaid members and HMOs that serve marketplace members to deliver the BHP. Using the same carriers will enable people to move between programs when income fluctuates without needing to navigate new providers or sources of care. DCHBX will maintain continuity of coverage and continuity of care for those who are no longer eligible for Medicaid by keeping people enrolled in the same MCO.

The District will build upon the existing coordination between its current marketplace and Medicaid eligibility systems and processes that work to enroll a person in the appropriate program, redetermine a person upon change in eligibility, and preclude duplicate enrollments to ensure appropriate use of taxpayer dollars.

Section 6: Premiums and Cost-sharing

This section of the Blueprint collects information from the state documenting compliance with requirements for establishing premiums and cost-sharing. Additionally, it provides CMS general information about the states planned premium and cost sharing structures and administration.

Premiums

Premium Assurances

The BHP will have no premium.

The State assures that (check all that apply):

☒ The monthly premium imposed on any enrollee does not exceed the monthly premium the individual would have been required to pay had he/she been enrolled in the applicable benchmark plan as defined in the tax code.

☒ When determining premiums, the State has taken into account reductions in the premium resulting from the premium tax credit that the enrollee would have been paid if he/she were in the Exchange.

☒ It will make the amount of premiums for all standard health plans available to any member of the public either through posting on a website or upon request. Additionally, enrollees will be notified of premiums at the time of enrollment, reenrollment or when premiums change, along with ways to report changes in income that might affect premiums.

Please provide the web address or other source for public access to premiums.
Web Address:

N/A

Other Source:

N/A

Please describe:

1. The group(s) of enrollees subject to premiums, including any variation by FPL, and the applicable premiums.

No BHP enrollees will have premiums.

2. The collection method and procedure for the payment of premiums.

N/A

3. The consequences for an enrollee or applicant who does not pay a premium, including grace periods and re-enrollment procedures.

N/A

Cost-Sharing

Cost-Sharing Assurances

N/A. Our goal is no cost-sharing. Should federal law change, we will make appropriate changes.

The State assures that (check all that apply):

☒ Cost sharing imposed on enrollees meets the standards imposed by 45 CFR 156.420(c), 45 CFR 156.420(e), 45 CFR 156.420(a)(1) and 45 CFR 156.420(a)(2).

☒ Cost sharing for Indians meets the standards of 45 CFR 156.420(b)(1) and (d).

☒ The State has not imposed cost sharing for preventive health services or items as defined in accordance with 45 CFR 147.130.

☒ The State has provided the amount and type of cost-sharing for each standard health plan that is applicable to every income level either on a public website or upon request to any member of the public, and specifically to applicants at the time of enrollment, reenrollment or when cost-sharing and coverage limitations change, along with ways to report changes in income that might affect cost-sharing amounts.

Please provide the web address or other source for public access to cost-sharing rules.
Web Address:

N/A

Other Source:

N/A

Please describe:

1. The group(s) subject to cost sharing.

N/A. Our goal is no cost-sharing. Should federal law change, we will make appropriate changes.

2. All copayments, co-insurance, and deductibles, by service.

N/A. Our goal is no cost-sharing. Should federal law change, we will make appropriate changes.

3. The system in place to monitor compliance with cost-sharing protections described above.

N/A. Our goal is no cost-sharing. Should federal law change, we will make appropriate changes.

Disenrollment Procedures for Non-Payment of Premiums

The BHP will have no premium.

Has the state elected to offer the enrollment periods equal to the Exchange defined at 45 CFR 155.410 and 420?
Choose Yes or No

If yes, check the box on the right to indicate the state assures that it will comply with the premium grace periods standards at 45 CFR 156.270 prior to disenrollment and that it will not restrict reenrollment beyond the next open enrollment period. ☐

If no, check the box on the right to indicate the state assures that it is providing a minimum grace period of 30 days for the payment of any required premium prior to disenrollment and that it will comply with reenrollment standards set forth in 457.570(c). ☐

If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is:

Enter number of days.

Section 7: Operational Assessment

The State assures that it can or will be able to:

	Full Assurance (Indicate with an "X" to signal assurance)	**Contingent Assurance** (Indicate with an "X" to signal assurance)
Eligibility and Renewals		
Accept an application online, via paper and via phone and provide in alternative formats in accordance with 42 CFR §600.310(b).	☒	☐
Return an accurate and timely eligibility result for all BHP eligible applicants.	☒	☐
Process a reported change and redetermine eligibility.	☒	☐
Comply with the ex-parte renewal process.	☒	☐
Issue an eligibility notice and share such notice with CMS.	☒	☐
Issue a renewal notice and share such notice with CMS.	☒	☐
Ability to terminate/disenroll from BHP for a variety of reasons, such as reaching age 65, obtaining MEC.	☒	☐
Issue termination/disenrollment notice to enrollees.	☒	☐
Benefits and Cost-Sharing		
Exempt American Indians from Cost-sharing.	☒	☐
Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing limits.	☒	☐
Premium Payment and Plan Enrollment		
Issue an accurate and timely premium invoice. **(N/A)**	☐	☐
Receipt and apply the premium payment correctly. **(N/A)**	☐	☐
Notify enrollee of health plan choices and complete plan enrollment.	☒	☐
Issue a health plan disenrollment notice.	☒	☐
Coordinate enrollment with other Insurance Affordability Programs		
Transfer accounts and provide notification in accordance with 42 CFR 600.330(c) through (e).	☒	☐

Contingency Descriptions

Please describe the contingency or dependency that limit full assurance.

Click or tap here to enter text.

Please describe any mitigation steps that will be in place and the date by which a full assurance will be possible.

Click or tap here to enter text.

Section 8: Standard Health Plan

This final section of the BHP Blueprint is a benefits description that allows a state to define the standard health plan(s) that will be offered under the BHP. The standard health plan is the set of benefits, including limitations on those benefits for which a state will contract. States are required by statute to offer the Essential Health Benefits (EHB) that are equally required in the Marketplace. States are also required to define those benefits using any of the base-benchmark or reference plans set forth at 45 CFR 156.100 (which could be a different base-benchmark or reference plan than is used for Marketplace or for Medicaid purposes). The benefits description below maps the base-benchmark plan to the EHB categories.

The Blueprint will not be a complete submission without the benefits description below defining the standard health plan offered under BHP.

Standard Health Plan

State Name: District of Columbia

Transmittal Number: Click or tap here to enter text.

Benefits description

The BHP will be the District of Columbia's EHB-Benchmark plan available at: https://www.cms.gov/marketplace/resources/data/essential-health-benefits#District_of_Columbia.

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

_____
Alice Weiss, Acting Director, on behalf of
Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Date of Interim Certification (mm/dd/yyyy) Implementation Date (mm/dd/yyyy)

_____ _____

Full Certification:

Secretary/Secretary's Designee
/Signed by Alice Weiss/

_____ ___
Alice Weiss, Acting Director, on behalf of
Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Date of Full Certification (mm/dd/yyyy) Implementation Date (mm/dd/yyyy)

September 30, 2025 January 1, 2026

Revised Certification:

Secretary/Secretary's Designee

_____
Alice Weiss, Acting Director, on behalf of
Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Date of Revised Certification (mm/dd/yyyy) Implementation Date (mm/dd/yyyy)

_____ _____