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118TH CONGRESS
1ST SESSION

H. R. 3004

To amend the Internal Revenue Code of 1986 to provide for a temporary expansion of health insurance premium tax credits for certain low-income populations, and to amend title XIX of the Social Security Act to establish a Federal Medicaid program.

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 2023

Mrs. FLETCHER introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Internal Revenue Code of 1986 to provide for a temporary expansion of health insurance premium tax credits for certain low-income populations, and to amend title XIX of the Social Security Act to establish a Federal Medicaid program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Affordable Care Coverage Expansion and Support for States Act'' or the ''ACCESS Act''.

SEC. 2. TEMPORARY EXPANSION OF HEALTH INSURANCE PREMIUM TAX CREDITS FOR CERTAIN LOW-INCOME POPULATIONS.

(a) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986 is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

''(h) CERTAIN TEMPORARY RULES BEGINNING IN 2024.—With respect to any taxable year beginning after December 31, 2023, and before January 1, 2027—

''(1) ELIGIBILITY FOR CREDIT NOT LIMITED BASED ON INCOME.—Subsection (c)(1)(A) shall be disregarded in determining whether a taxpayer is an applicable taxpayer.

''(2) CREDIT ALLOWED TO CERTAIN LOW-INCOME EMPLOYEES OFFERED EMPLOYER-PROVIDED COVERAGE.—Subclause (II) of subsection (c)(2)(C)(i) shall not apply if the taxpayer's household income does not exceed 138 percent of the poverty line for a family of the size involved. Subclause (II) of subsection (c)(2)(C)(i) shall also not apply to an individual described in the last sentence of such subsection if the taxpayer's household income does not exceed 138 percent of the poverty line for a family of the size involved.

''(3) CREDIT ALLOWED TO CERTAIN LOW-INCOME EMPLOYEES OFFERED QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—A qualified small employer health reimbursement arrangement shall not be treated as constituting affordable coverage for an employee (or any spouse or dependent of such employee) for any months of a taxable year if the employee's household income for such taxable year does not exceed 138 percent of the poverty line for a family of the size involved.

''(4) LIMITATIONS ON RECAPTURE.—

''(A) IN GENERAL.—In the case of a taxpayer whose household income is less than 200 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subsection (f)(2)(A) shall in no event exceed $300 (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

''(B) LIMITATION ON INCREASE FOR CERTAIN NON-FILERS.—In the case of any taxpayer who would not be required to file a return of tax for the taxable year but for any require-

ment to reconcile advance credit payments under subsection (f), if an Exchange established under title I of the Patient Protection and Affordable Care Act has determined that—

"(i) such taxpayer is eligible for advance payments under section 1412 of such Act for any portion of such taxable year, and

"(ii) such taxpayer's household income for such taxable year is projected to not exceed 138 percent of the poverty line for a family of the size involved,

subsection (f)(2)(A) shall not apply to such taxpayer for such taxable year and such taxpayer shall not be required to file such return of tax.

"(C) INFORMATION PROVIDED BY EXCHANGE.—The information required to be provided by an Exchange to the Secretary and to the taxpayer under subsection (f)(3) shall include such information as is necessary to determine whether such Exchange has made the determinations described in clauses (i) and (ii) of subparagraph (B) with respect to such taxpayer.".

(b) EMPLOYER SHARED RESPONSIBILITY PROVISION NOT APPLICABLE WITH RESPECT TO CERTAIN LOW-INCOME TAXPAYERS RECEIVING PREMIUM ASSISTANCE.—Section 4980H(c)(3) is amended to read as follows:

''(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—

''(A) IN GENERAL.—The term 'applicable premium tax credit and cost-sharing reduction' means—

''(i) any premium tax credit allowed under section 36B,

''(ii) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

''(iii) any advance payment of such credit or reduction under section 1412 of such Act.

''(B) EXCEPTION WITH RESPECT TO CERTAIN LOW-INCOME TAXPAYERS.—Such term shall not include any premium tax credit, cost-sharing reduction, or advance payment otherwise described in subparagraph (A) if such credit, reduction, or payment is allowed or paid for a taxable year of an employee (beginning

after December 31, 2023, and before January 1, 2027) with respect to which—

"(i) an Exchange established under title I of the Patient Protection and Affordable Care Act has determined that such employee's household income for such taxable year is projected to not exceed 138 percent of the poverty line for a family of the size involved, or

"(ii) such employee's household income for such taxable year does not exceed 138 percent of the poverty line for a family of the size involved.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2023.

SEC. 3. CLOSING THE MEDICAID COVERAGE GAP.

(a) FEDERAL MEDICAID PROGRAM TO CLOSE COVERAGE GAP IN NONEXPANSION STATES.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new section:

"SEC. 1948. FEDERAL MEDICAID PROGRAM TO CLOSE COVERAGE GAP IN NONEXPANSION STATES.

"(a) ESTABLISHMENT.—In the case of a State that the Secretary determines (based on the State plan under

this title, waiver of such plan, or other relevant information) is not expected to expend amounts under the State plan (or waiver of such plan) for all individuals described in section 1902(a)(10)(A)(i)(VIII) during a year (beginning with 2027) (in this section defined as 'a coverage gap State', with respect to such year), the Secretary shall (including through contract with eligible entities (as specified by the Secretary), consistent with subsection (b)) provide for the offering to such individuals residing in such State of a health benefits plan (in this section referred to as the 'Federal Medicaid program' or the 'Program'), for each quarter during the period beginning on January 1 of such year, and ending with the last day of the first quarter during which the State provides medical assistance to all such individuals under the State plan (or waiver of such plan). Under the Federal Medicaid program, the Secretary—

''(1) may use the Federally Facilitated Marketplace to facilitate eligibility determinations and enrollments under the Federal Medicaid Program and shall establish a set of eligibility rules to be applied under the Program in a manner consistent with section 1902(e)(14); and

''(2) shall establish benefits, beneficiary protections, and access to care standards by, at a minimum—

''(A) establishing a minimum set of benefits to be provided (and providing such benefits) under the Federal Medicaid program, which shall be in compliance with the requirements of section 1937 and shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) to the same extent as medical assistance provided to such an individual under this title (without application of this section) is required under section 1902(k)(1) to consist of such benchmark coverage or benchmark equivalent coverage;

''(B) applying the provisions of sections 1902(a)(8), 1902(a)(34) (which may be applied in accordance with such phased-in implementation as the Secretary deems necessary, but beginning as soon as practicable), and 1943 with respect to such an individual, benefits under the Federal Medicaid program, and making application for such benefits (which may be in accordance with a phased-in implementation as the

Secretary deems necessary, but beginning as soon as practicable) in the same manner as such provisions would apply to such an individual, medical assistance under this title (other than pursuant to this section), and making application for such medical assistance under this title (other than pursuant to this section); and providing that redeterminations and appeals of eligibility and coverage determinations of services (including benefit reductions, terminations, and suspension) shall be conducted under the Federal Medicaid program in accordance with a Federal fair hearing process established by the Secretary that is subject to the same requirements as applied with respect to redeterminations and appeals of eligibility, and with respect to coverage of services (including benefit reductions, terminations, and suspension), under a State plan under this title and that may provide for such fair hearings related to denials of eligibility (based on modified adjusted gross income eligibility determinations) to be conducted through the Federally Facilitated Marketplace for Exchanges;

"(C) applying, in accordance with subsection (d), the provisions of section 1927 (other than subparagraphs (B) and (C) of subsection (b)(1) of such section) with respect to the Secretary and payment under the Federal Medicaid program for covered outpatient drugs with respect to a rebate period in the same manner and to the same extent as such provisions apply with respect to a State and payment under the State plan for covered outpatient drugs with respect to the rebate period; and

"(D) applying the provisions of sections 1902(a)(14), 1902(a)(23), 1902(a)(47), and 1920 through 1920C (as applicable) to the Federal Medicaid program and such individuals enrolled in such program in the same manner and to the same extent as such provisions apply to a State plan and such individuals eligible for medical assistance under the State plan, and applying the provisions of section 1902(a)(30)(A) with respect to medical assistance available under the Federal Medicaid program in the same manner and to the same extent as such provisions apply to medical assist-

ance under a State plan under this title, except that—

"(i) the Secretary shall provide that no cost sharing shall be applied under the Federal Medicaid program;

"(ii) the Secretary may waive the provisions of subparagraph (A) of section 1902(a)(23) to the extent deemed appropriate to facilitate the implementation of managed care; and

"(iii) in applying the provisions of section 1902(a)(47) and sections 1920 through 1920C, the Secretary—

"(I) shall establish a single presumptive eligibility process for individuals eligible under the Federal Medicaid program, under which the Secretary may contract with entities to carry out such process; and

"(II) may apply such provisions and process in accordance with such phased-in implementation as the Secretary deems necessary, but beginning as soon as practicable.

"(b) ADMINISTRATION OF FEDERAL MEDICAID PROGRAM THROUGH CONTRACTS WITH MEDICAID MANAGED CARE ORGANIZATION AND THIRD PARTY PLAN ADMINISTRATOR REQUIREMENTS.—

"(1) IN GENERAL.—For the purpose of administering the benefits under the Program (across all coverage gap geographic areas (as defined in paragraph (8))) to provide medical assistance to individuals described in section 1902(a)(10)(A)(i)(VIII) enrolled under the Federal Medicaid program and residing in such areas, the Secretary shall solicit bids described in paragraph (2) and enter into contracts with a total of at least 2 eligible entities (as specified by the Secretary, which may be a medicaid managed care organization (in this section defined as including a managed care organization described in section 1932(a)(1)(B)(i), a prepaid inpatient health plan, and a prepaid ambulatory health plans (as defined in section 438.2 of title 42, Code of Federal Regulations)), a third party plan administrator, or both). An eligible entity entering into a contract with the Secretary under this paragraph may administer such benefits as a Medicaid managed care organization (as so defined), in which case such contract shall be in accordance with paragraph (3) with

respect to such geographic area, or as a third-party administrator, in which case such contract shall be in accordance with paragraph (4) with respect to such geographic area. The Secretary may so contract with a Medicaid managed care organization or third party plan administrator in each coverage gap geographic area (and may specify which type of eligible entity may bid with respect to a coverage gap geographic area or areas) and may contract with more than one such eligible entity in the same coverage gap geographic area.

''(2) BIDS.—

''(A) IN GENERAL.—To be eligible to enter into a contract under this subsection, for a year, an entity shall submit (at such time, in such manner, and containing such information as specified by the Secretary) one or more bids to administer the Program in one or more coverage gap geographic areas, which reflects the projected monthly cost to the entity of furnishing benefits under the Program to an individual enrolled under the Program in such a geographic area (or areas) for such year.

''(B) SELECTION.—In selecting from bids submitted under subparagraph (A) for purposes

of entering into contracts with eligible entities under this subsection, with respect to a coverage gap geographic area, the Secretary shall take into account at least each of the following, with respect to each such bid:

''(i) Network adequacy (as proposed in the submitted bid).

''(ii) The amount, duration, and scope of benefits (such as value-added services offered in the submitted bid), as compared to the minimum set of benefits established by the Secretary under subsection (a)(2)(A).

''(iii) The amount of the bid, taking into account the average per member cost of providing medical assistance under State plans under this title (or waivers of such plans) to individuals enrolled in such plans (or waivers) who are at least 18 years of age and residing in the coverage gap geographic area, as well as the average cost of providing medical assistance under State plans under this title (and waivers of such plans) to individuals described in section 1902(a)(10)(A)(i)(VIII).

"(3) CONTRACT WITH MEDICAID MANAGED CARE ORGANIZATION.—In the case of a contract under paragraph (1) between the Secretary and an eligible entity administering benefits under the Program as a Medicaid managed care organization, with respect to one or more coverage gap geographic areas, the following shall apply:

"(A) The provisions of clauses (i) through (xi) of section 1903(m)(2)(A), clause (xii) of such section (to the extent such clause relates to subsections (b) and (f) of section 1932), and clause (xiii) of such section 1903(m)(2)(A) shall, to the greatest extent practicable, apply to the contract, to the Secretary, and to the Medicaid managed care organization, with respect to providing medical assistance under the Federal Medicaid program with respect to such area, in the same manner and to the same extent as such provisions apply to a contract under section 1903(m) between a State and an entity that is a Medicaid managed care organization (as defined in section 1903(m)(1)), to the State, and to the entity, with respect to providing medical assistance to individuals eligible for benefits under this title.

''(B) The provisions of section 1932(h) shall apply to the contract, Secretary, and Medicaid managed care organization.

''(C) The contract shall provide that the entity pay claims in a timely manner and in accordance with the provisions of section 1902(a)(37).

''(D) The contract shall provide that the Secretary shall make payments under this section to the entity, with respect to coverage of each individual enrolled under the Program in such a coverage gap geographic area with respect to which the entity administers the Program in an amount specified in the contract, subject to subparagraph (D)(ii) and paragraph (6).

''(E) The contract shall require—

''(i) the application of a minimum medical loss ratio (as calculated under subsection (d) of section 438.8 of title 42, Code of Federal Regulations (or any successor regulation)) for payment for medical assistance administered by the managed care organization under the Program, with respect to a year, that is equal to or great-

er than 85 percent (or such higher percent as specified by the Secretary); and

''(ii) in the case, with respect to a year, the minimum medical loss ratio (as so calculated) for payment for services under the benefits so administered is less than 85 percent (or such higher percent as specified by the Secretary under clause (i)), remittance by the organization to the Secretary of any payments (or portions of payments) made to the organization under this section in an amount equal to the difference in payments for medical assistance, with respect to the year, resulting from the organization's failure to meet such ratio for such year.

''(F) The contract shall require that the eligible entity submit to the Secretary the number of individuals enrolled in the Program with respect to each coverage gap geographic area and month with respect to which the contract applies and such additional information as specified by the Secretary for purposes of payment, program integrity, oversight, quality measure-

ment, or such other purpose specified by the Secretary.

"(G) The contract shall require that the eligible entity perform any other activity identified by the Secretary.

"(4) CONTRACT WITH A THIRD PARTY PLAN ADMINISTRATOR.—

"(A) IN GENERAL.—In the case of a contract under paragraph (1) between the Secretary and an eligible entity to administer the Program as a third party plan administrator, with respect to one or more coverage gap geographic areas, such contract shall provide that, with respect to medical assistance provided under the Federal Medicaid program to individuals who are enrolled in the Program with respect to such area (or areas)—

"(i) the third party plan administrator shall, consistent with such requirements as may be established by the Secretary—

"(I) establish provider networks, payment rates, and utilization management, consistent with the provisions of section 1902(a)(30)(A), as applied by subsection (a)(4);

''(II) pay claims in a timely manner and in accordance with the provisions of section 1902(a)(37);

''(III) submit to the Secretary the number of individuals enrolled in the Program with respect to each coverage gap geographic area and month with respect to which the contract applies and such additional information as specified by the Secretary for purposes of payment, program integrity, oversight, quality measurement, or such other purpose specified by the Secretary; and

''(IV) perform any other activity identified by the Secretary; and

''(ii) the Secretary shall make payments (for the claims submitted by the third party plan administrator and for an economic and efficient administrative fee) under this section to the third party plan administrator, with respect to coverage of each individual enrolled under the Program in a coverage gap geographic area with respect to which the third party plan admin-

istrator administers the Program in an amount determined under the contract, subject to subclause (VI)(bb) and paragraph (7).

''(B) THIRD PARTY PLAN ADMINISTRATOR DEFINED.—For purposes of this section, the term 'third party plan administrator' means an entity that satisfies such requirements as established by the Secretary, which shall include at least that such an entity administers health plan benefits, pays claims under the plan, establishes provider networks, sets payment rates, and are not risk-bearing entities.

''(5) ADMINISTRATIVE AUTHORITY.—The Secretary may take such actions as are necessary to administer this subsection, including by setting payment rates, setting network adequacy standards, establishing quality requirements, establishing reporting requirements, and specifying any other program requirements or standards necessary in contracting with specified entities under this subsection, and overseeing such entities, with respect to the administration of the Federal Medicaid program.

''(6) PREEMPTION.—In carrying out the duties under a contract entered into under paragraph (1)

between the Secretary and a Medicaid managed care organization or a third party plan administrator, with respect to a coverage gap State—

"(A) the Secretary may establish minimum standards and licensure requirements for such a Medicaid managed care organization or third party plan administrator for purposes of carrying out such duties; and

"(B) any provisions of law of that State which relate to the licensing of the organization or administrator and which prohibit the organization or administrator from providing coverage pursuant to a contract under this section shall be superseded.

"(7) PENALTIES.—In the case of an eligible entity with a contract under this section that fails to comply with the requirements of such entity pursuant to this section or such contract, the Secretary may withhold payment (or any portion of such payment) to such entity under this section in accordance with a process specified by the Secretary, impose a corrective action plan on such entity, or impose a civil monetary penalty on such entity in an amount not to exceed $10,000 for each such failure. In implementing this paragraph, the Secretary shall

have the authorities provided the Secretary under section 1932(e) and subparts F and I of part 438 of title 42, Code of Federal Regulations.

''(8) COVERAGE GAP GEOGRAPHIC AREA.—For purposes of this section, the term 'coverage gap geographic area' means an area of one or more coverage gap States, as specified by the Secretary, or any area within such a State, as specified by the Secretary.

''(c) PERIODIC DATA MATCHING.—The Secretary shall, including through contract, periodically verify the income of an individual enrolled in the Federal Medicaid program for a year, before the end of such year, to determine if there has been any change in the individual's eligibility for benefits under the program. For purposes of the previous sentence, the Secretary may verify income of an individual based on the prospective income of the individual for such year or based on current monthly income of the individual, as specified by the Secretary. In the case that, pursuant to such verification, an individual is determined to have had a change in income that results in such individual no longer be included as an individual described in section 1902(a)(10)(A)(i)(VIII), the Secretary shall apply the same processes and protections as States are required under this title to apply with respect to an indi-

vidual who is determined to have had a change in income that results in such individual no longer being included as eligible for medical assistance under this title (other than pursuant to this section).

''(d) DRUG REBATES.—For purposes of subsection (a)(2)(B), in applying section 1927, the Secretary shall (either directly or through contracts)—

''(1) require an eligible entity with a contract under subsection (b) to report the data required to be reported under section 1927(b)(2) by a State agency and require such entity to submit to the Secretary rebate data, utilization data, and any other information that would otherwise be required under section 1927 to be submitted to the Secretary by a State;

''(2) shall take such actions as are necessary and develop or adapt such processes and mechanisms as are necessary to report and collect data as is necessary and to bill and track rebates under section 1927, as applied pursuant to subsection (a)(2)(B) for drugs that are provided under the Federal Medicaid program;

''(3) provide that the coverage requirements of prescription drugs under the Federal Medicaid pro-

gram comply with the coverage requirements section 1927; and

''(4) require that in order for payment to be available under the Federal Medicaid program or under section 1903(a) for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement to provide rebates under section 1927 to the Federal Medicaid program in the same form and manner as the manufacturer is required to provide rebates under an agreement described in section 1927(b) to a State Medicaid program under this title.

''(e) TRANSITIONS.—

''(1) FROM EXCHANGE PLANS ONTO FEDERAL MEDICAID PROGRAM.—The Secretary shall provide for a process under which, in the case of individuals described in section 1902(a)(10)(A)(i)(VIII) who are enrolled in qualified health plans through an Exchange in a coverage gap State, the Secretary takes such steps as are necessary to transition such individuals to coverage under the Federal Medicaid program. Such process shall apply procedures described in section 1943(b)(1)(C) to screen for eligibility and enrollment under the Federal Medicaid program in the same manner as such procedures screen for eligi-

bility and enrollment under qualified health plans through an Exchange established under title I of the Patient Protection and Affordable Care Act.

''(2) IN CASE COVERAGE GAP STATE BEGINS PROVIDING COVERAGE UNDER STATE PLAN.—The Secretary shall provide for a process for, in the case of a coverage gap State in which the State begins to provide medical assistance to individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan (or waiver of such plan) and the Federal Medicaid program ceases to be offered, transitioning individuals from such program to the State plan (or waiver), as eligible, including a process for transitioning all eligibility redeterminations.

''(f) COORDINATION WITH AND ENROLLMENT THROUGH EXCHANGES.—The Secretary shall take such actions as are necessary to provide, in the case of a coverage gap State in which the Federal Medicaid program is offered, for the availability of information on, determinations of eligibility for, and enrollment in such program through and coordinated with the Exchange established with respect to such State under title I of the Patient Protection and Affordable Care Act.

''(g) THIRD PARTY LIABILITY.—The provisions of section 1902(a)(25) shall apply with respect to the Fed-

eral Medicaid program, the Secretary, and the eligible entities with a contract under subsection (b) in the same manner as such provisions apply with respect to State plans under this title (or waiver of such plans) and the State or local agency administering such plan (or waiver). The Secretary may specify a timeline (which may include a phase-in) for implementing this subsection.

''(h) FRAUD AND ABUSE PROVISIONS.—Provisions of law (other than criminal law provisions) identified by the Secretary by regulation, in consultation (as appropriate) with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under this title or title XI, such as the False Claims Act, as well as provisions of law (other than criminal law provisions) identified by the Secretary that provide oversight authority, shall also apply to the Federal Medicaid program.

''(i) MAINTENANCE OF EFFORT.—

''(1) PAYMENT.—

''(A) IN GENERAL.—In the case of a State that, as of January 1, 2027, is expending amounts for all individuals described in section 1902(a)(10)(A)(i)(VIII) under the State plan (or waiver of such plan) and that stops expending amounts for all such individuals under the

State plan (or waiver of such plan), such State shall for each quarter beginning after January 1, 2027, during which such State does not expend amounts for all such individuals provide for payment under this subsection to the Secretary of the product of—

''(i) 10 percent of, subject to subparagraph (B), the average monthly per capita costs expended under the State plan (or waiver of such plan) for such individuals during the most recent previous quarter with respect to which the State expended amounts for all such individuals; and

''(ii) the sum, for each month during such quarter, of the number of individuals enrolled under such program in such State.

''(B) ANNUAL INCREASE.—For purposes of subparagraph (A), in the case of a State with respect to which such subparagraph applies with respect to a period of consecutive quarters occurring during more than one calendar year, for such consecutive quarters occurring during the second of such calendar years or a subsequent calendar year, the average monthly per capita costs for each such quarter for such

State determined under subparagraph (A)(i), or this subparagraph, shall be annually increased by the Secretary by the percentage increase in Medicaid spending under this title during the preceding year (as determined based on the most recent National Health Expenditure data with respect to such year).

''(2) FORM AND MANNER OF PAYMENT.—Payment under paragraph (1) shall be made in a form and manner specified by the Secretary.

''(3) COMPLIANCE.—If a State fails to pay to the Secretary an amount required under paragraph (1), interest shall accrue on such amount at the rate provided under section 1903(d)(5). The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section 1903(a), in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

''(4) DATA MATCH.—The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of individuals enrolled under the Federal Medicaid program under section 1948 in a coverage gap State (as referenced in subsection (a) of such section) for pur-

poses of computing the amount under paragraph (1).

''(5) NOTICE.—The Secretary shall notify each State described in paragraph (1) not later than a date specified by the Secretary that is before the beginning of each quarter (beginning with 2027) of the amount computed under paragraph (1) for the State for that year.

''(j) APPROPRIATIONS.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, for each fiscal year such sums as are necessary to carry out subsections (a) through (i) of this section.''.

(b) DRUG REBATE CONFORMING AMENDMENT.—Section 1927(a)(1) of the Social Security Act (42 U.S.C. 1396r–8(a)(1)) is amended in the first sentence—

(1) by striking ''or under part B of title XVIII'' and inserting '', under the Federal Medicaid program under section 1948, or under part B of title XVIII''; and

(2) by inserting ''including as such subsection is applied pursuant to subsections (a)(2)(C) and (d) of section 1948 with respect to the Federal Medicaid program,'' before ''and must meet''.

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