

## § 400.203

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 400.202, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at [www.govinfo.gov](http://www.govinfo.gov).

### § 400.203 Definitions specific to Medicaid.

As used in connection with the Medicaid program, unless the context indicates otherwise—

*Applicant* means an individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. This includes an individual (who need not be alive at the time of application) whose application is submitted through a representative or a person acting responsibly for the individual.

*Federal financial participation* (FFP) means the Federal Government's share of a State's expenditures under the Medicaid program.

*FMAP* stands for the Federal medical assistance percentage, which is used to calculate the amount of Federal share of State expenditures for services.

*Intellectual disability* means the condition that was previously referred to as mental retardation.

*Medicaid agency* or *agency* means the single State agency administering or supervising the administration of a State Medicaid plan.

*Nursing facility* (NF), effective October 1, 1990, means an SNF or an ICF participating in the Medicaid program.

*PCCM* stands for primary care case manager.

*PCP* stands for primary care physician.

*Provider* means either of the following:

(1) For the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency.

(2) For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

*Services* means the types of medical assistance specified in section 1905(a) of the Act and defined in subpart A of part 440 of this chapter.

## 42 CFR Ch. IV (10–1–23 Edition)

*State* means the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

*State plan* or *the plan* means a comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

[48 FR 12534, Mar. 25, 1983, as amended at 50 FR 33029, Aug. 16, 1985; 56 FR 8852, Mar. 1, 1991; 57 FR 29155, June 30, 1992; 67 FR 41094, June 14, 2002; 77 FR 29028, May 16, 2012]

### Subpart C [Reserved]

## PART 401—GENERAL ADMINISTRATIVE REQUIREMENTS

### Subpart A [Reserved]

### Subpart B—Confidentiality and Disclosure

Sec.

- 401.101 Purpose and scope.
- 401.102 Definitions.
- 401.105 Rules for disclosure.
- 401.106 Publication.
- 401.108 CMS rulings.
- 401.109 Precedential Final Decisions of the Secretary.
- 401.110 Publications for sale.
- 401.112 Availability of administrative staff manuals.
- 401.116 Availability of records upon request.
- 401.118 Deletion of identifying details.
- 401.120 Creation of records.
- 401.126 Information or records that are not available.
- 401.128 Where requests for records may be made.
- 401.130 Materials available at social security district offices and branch offices.
- 401.132 Materials in field offices of the Office of Hearings and Appeals, SSA.
- 401.133 Availability of official reports on providers and suppliers of services, State agencies, intermediaries, and carriers under Medicare.
- 401.134 Release of Medicare information to State and Federal agencies.
- 401.135 Release of Medicare information to the public.
- 401.136 Requests for information or records.
- 401.140 Fees and charges.
- 401.144 Denial of requests.
- 401.148 Administrative review.
- 401.152 Court review.

### Subpart C [Reserved]

**Subpart D—Reporting and Returning of Overpayments**

- 401.301 Basis and scope.
- 401.303 Definitions.
- 401.305 Requirements for reporting and returning of overpayments.

**Subpart E [Reserved]****Subpart F—Claims Collection and Compromise**

- 401.601 Basis and scope.
- 401.603 Definitions.
- 401.605 Omissions not a defense.
- 401.607 Claims collection.
- 401.613 Compromise of claims.
- 401.615 Payment of compromise amount.
- 401.617 Suspension of collection action.
- 401.621 Termination of collection action.
- 401.623 Joint and several liability.
- 401.625 Effect of CMS claims collection decisions on appeals.

**Subpart G—Availability of Medicare Data for Performance Measurement**

- 401.701 Purpose and scope.
- 401.703 Definitions.
- 401.705 Eligibility criteria for qualified entities.
- 401.707 Operating and governance requirements for qualified entities.
- 401.709 The application process and requirements.
- 401.711 Updates to plans submitted as part of the application process.
- 401.713 Ensuring the privacy and security of data.
- 401.715 Selection and use of performance measures.
- 401.716 Non-public analyses.
- 401.717 Provider and supplier requests for error correction.
- 401.718 Dissemination of data.
- 401.719 Monitoring and sanctioning of qualified entities.
- 401.721 Terminating an agreement with a qualified entity.
- 401.722 Qualified clinical data registries.

AUTHORITY: Secs. 1102, 1871, and 1874(e) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395w-5) and sec. 105, Pub. L. 114-10, 129 Stat. 87.

**Subpart A [Reserved]****Subpart B—Confidentiality and Disclosure**

SOURCE: 46 FR 55696, Nov. 12, 1981, unless otherwise noted.

**§ 401.101 Purpose and scope.**

(a) The regulations in this subpart:

(1) Implement section 1106(a) of the Social Security Act as it applies to the Centers for Medicare & Medicaid Services (CMS). The rules apply to information obtained by officers or employees of CMS in the course of administering title XVIII of the Social Security Act (Medicare), information obtained by Medicare intermediaries or carriers in the course of carrying out agreements under sections 1816 and 1842 of the Social Security Act, and any other information subject to section 1106(a) of the Social Security Act;

(2) Relate to the availability to the public, under 5 U.S.C. 552, of records of CMS and its components. They set out what records are available and how they may be obtained; and

(3) Supplement the regulations of the Department of Health and Human Services relating to availability of information under 5 U.S.C. 552, codified in 45 CFR part 5, and do not replace or restrict them.

(b) Except as authorized by the rules in this subpart, no information described in paragraph (a)(1) of this section shall be disclosed. The procedural rules in this subpart (§§ 401.106 through 401.152) shall be applied to requests for information which is subject to the rules for disclosure in this subpart.

(c) Requests for information which may not be disclosed according to the provisions of this subpart shall be denied under authority of section 1106(a) of the Social Security Act and this subpart, and furthermore, such requests which have been made pursuant to the Freedom of Information Act shall be denied under authority of an appropriate Freedom of Information Act exemption, 5 U.S.C. 552(b).

**§ 401.102 Definitions.**

For purposes of this subpart:

*Act* means the Social Security Act.

*Freedom of Information Act rules* means the substantive mandatory disclosure provisions of the Freedom of Information Act, 5 U.S.C. 552 (including the exemptions from mandatory disclosure, 5 U.S.C. 552(b), as implemented by the Department's public information regulation, 45 CFR part 5, subpart F