

## SUBCHAPTER A—GENERAL PROVISIONS

### PART 400—INTRODUCTION; DEFINITIONS

#### Subpart A [Reserved]

#### Subpart B—Definitions

Sec.

400.200 General definitions.

400.202 Definitions specific to Medicare.

400.203 Definitions specific to Medicaid.

#### Subpart C [Reserved]

AUTHORITY: 42 U.S.C. 1302 and 1395hh and 44 U.S.C. Chapter 35.

#### Subpart A [Reserved]

#### Subpart B—Definitions

##### § 400.200 General definitions.

In this chapter, unless the context indicates otherwise—

*Act* means the Social Security Act, and titles referred to are titles of that Act.

*Administrator* means the Administrator, Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).

*ALJ* stands for administrative law judge.

*Area* means the geographical area within the boundaries of a State, or a State or other jurisdiction, designated as constituting an area with respect to which a Professional Standards Review Organization or a Utilization and Quality Control Peer Review Organization has been or may be designated.

*Beneficiary* means a person who is entitled to Medicare benefits and/or has been determined to be eligible for Medicaid.

*CMP* stands for competitive medical plan.

*Conditions of participation* includes requirements for participation as the latter term is used in part 483 of this chapter.

*Condition level* deficiencies includes deficiencies with respect to “level A requirements” as the latter term is used in parts 442 and 483 of this chapter.

*CORF* stands for comprehensive outpatient rehabilitation facility.

*CFR* stands for Code of Federal Regulations.

*CMS* stands for Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

*CY* stands for calendar year.

*DAB* stands for Departmental Appeals Board.

*Department* means the Department of Health and Human Services (HHS), formerly the Department of Health, Education, and Welfare.

*ESRD* stands for end-stage renal disease.

*FDA* stands for the Food and Drug Administration.

*FQHC* means Federally qualified health center.

*FR* stands for FEDERAL REGISTER.

*FY* stands for fiscal year.

*HCPP* stands for health care prepayment plan.

*HHS* stands for the Department of Health and Human Services.

*HHA* stands for home health agency.

*HMO* stands for health maintenance organization.

*ICF* stands for intermediate care facility.

*ICF/IID* stands for intermediate care facility for individuals with intellectual disabilities.

*Medicaid* means medical assistance provided under a State plan approved under title XIX of the Act.

*Medicare* means the health insurance program for the aged and disabled under title XVIII of the Act.

*Medicare Savings Programs* (MSPs) has the same meaning described in § 435.4 of this chapter.

*NCD* stands for national coverage determination.

*OASDI* stands for the Old Age, Survivors, and Disability Insurance program under title II of the Act.

*OIG* stands for the Department’s Office of the Inspector General.

*Public Health Emergency* (PHE) means the Public Health Emergency determined to exist nationwide as of January 27, 2020, by the Secretary pursuant to section 319 of the Public Health

## § 400.202

Service Act on January 31, 2020, as a result of confirmed cases of COVID-19, including any subsequent renewals.

*QDWI* stands for Qualified Disabled and Working Individual.

*QIO* stands for quality improvement organization.

*QMB* stands for Qualified Medicare Beneficiary.

*Qualified Disabled and Working Individual* means an individual who—

(1) Is eligible to enroll for Medicare Part A under section 1818A of the Act.

(2) Has income, as determined in accordance with SSI methodologies, that does not exceed 200 percent of the Federal poverty guidelines (as defined and revised annually by the Office of Management and Budget) for a family of the size of the individual's family;

(3) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the relevant maximum amount established, for SSI eligibility, for an individual or for an individual and his or her spouse; and

(4) Is not otherwise eligible for Medicaid.

*Qualified Medicare Beneficiary (QMB)* means an individual described in § 435.123 of this chapter.

*Qualifying Individual (QI)* means an individual described in § 435.125 of this chapter.

*Quality improvement organization* means an organization that has a contract with CMS, under part B of title XI of the Act, to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare beneficiaries.

*Regional Administrator* means a Regional Administrator of CMS.

*Regional Office* means one of the regional offices of CMS.

*RHC* stands for rural health clinic.

*RRB* stands for Railroad Retirement Board.

*Secretary* means the Secretary of Health and Human Services.

*SNF* stands for skilled nursing facility.

*Social security benefits* means monthly cash benefits payable under section 202 or 223 of the Act.

*Specified Low-Income Medicare Beneficiary (SLMB)* means an individual described in § 435.124 of this chapter.

## 42 CFR Ch. IV (10–1–24 Edition)

*SSA* stands for Social Security Administration.

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

*U.S.C.* stands for United States Code.

[48 FR 12534, Mar. 25, 1983]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 400.200, 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).

### § 400.202 Definitions specific to Medicare.

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

*Carrier* means an entity that has a contract with CMS to determine and make Medicare payments for Part B benefits payable on a charge basis and to perform other related functions.

*Critical access hospital (CAH)* means a facility designated by HFCA as meeting the applicable requirements of section 1820 of the Act and of subpart F of part 485 of this chapter.

*Departmental Appeals Board* means: (1) Except as provided in paragraphs (2) and (3) of this definition, a Board established in the office of the Secretary, whose members act in panels to provide impartial review of disputed decisions made by operating components of the Department or by ALJs.

(2) For purposes of review of ALJ decisions under part 405, subparts G and H; part 417, subpart Q; part 422, subpart M; and part 478, subpart B of this chapter, the Medicare Appeals Council designated by the Board Chair.

(3) For purposes of part 426 of this chapter, a Member of the Board and, at the discretion of the Board Chair, any other Board staff appointed by the Board Chair to perform a review under that part.

*Entitled* means that an individual meets all the requirements for Medicare benefits.

*Essential access community hospital (EACH)* means a hospital designated by CMS as meeting the applicable requirements of section 1820 of the Act and of subpart G of part 412 of this chapter, as in effect on September 30, 1997.