(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* means an individual who—

(1) Is entitled to Medicare Part A, with or without payment of premiums, but is not entitled solely because he or she is eligible to enroll as a QDWI;

(2) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the maximum amount established for SSI eligibility; and

(3) Has income, as determined in accordance with SSI methodologies, that does not exceed 100 percent of the Federal poverty guidelines.

*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.

*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, as amended at 49 FR 7206, Feb. 27, 1984; 50 FR 15326 and 15358, Apr. 17, 1985; 50 FR 41886, Oct. 16, 1985; 51 FR 43197, Dec. 1, 1986; 52 FR 27764, July 23, 1987; 56 FR 8852, Mar. 1, 1991; 56 FR 38077, Aug. 12, 1991; 57 FR 24975, June 12, 1992; 57 FR 55912, Nov. 25, 1992; 63 FR 35065, June 26, 1998; 63 FR 52611, Oct. 1, 1998; 63 FR 68690, Dec. 14, 1998; 66 FR 39452, July 31, 2001; 67 FR 36540, May 24, 2002]

### § 400.202 Definitions specific to Medicare.

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

*Beneficiary* means a person who is entitled to Medicare benefits.

*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.

*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.

*GME* stands for graduate medical education.

*Hospital insurance benefits* means payments on behalf of, and in rare circumstances directly to, an entitled individual for services that are covered under Part A of title XVIII of the Act.

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

*Medicare Part A* means the hospital insurance program authorized under Part A of title XVIII of the Act.

*Medicare Part B* means the supplementary medical insurance program authorized under Part B of title XVIII of the Act.

*National coverage determination (NCD)* means a national policy determination regarding the coverage status of a particular service, that makes under section 1862(a)(1) of the Act, and publishes as a FEDERAL REGISTER notice or CMS Ruling. (The term does not include coverage changes mandated by statute.)

*Nonparticipating supplier* means a supplier that does not have an agreement with CMS to participate in Part B of Medicare in effect on the date of the service.

*Participating supplier* means a supplier that has an agreement with CMS to participate in Part B of Medicare in effect on the date of the service.

*Payment on an assignment-related basis* means payment for Part B services—

(1) To a physician or other supplier that accepts assignment from the beneficiary, in accordance with § 424.55 or § 424.56 of this chapter;

(2) To a physician or other supplier after the beneficiary's death, in accordance with § 424.64(c)(1) of this chapter; or

(3) To an entity that pays the physician or other supplier under a health benefit plan, in accordance with § 424.66 of this chapter.

*Provider* means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

*Railroad retirement benefits* means monthly benefits payable to individuals under the Railroad Retirement Act of 1974 (45 U.S.C. beginning at section 231).

*Services* means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital, CAH, or SNF facilities.

*Supplementary medical insurance benefits* means payment to or on behalf of an entitled individual for services covered under Part B of title XVIII of the Act.

*Supplier* means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

[48 FR 12534, Mar. 25, 1983, as amended at 48 FR 56024, Dec. 16, 1983; 49 FR 3658, Jan. 30, 1984; 51 FR 43197, Dec. 1, 1986; 52 FR 27764, July 23, 1987; 55 FR 24567, June 18, 1990; 56 FR 8852, Mar. 1, 1991; 58 FR 30666, May 26, 1993; 59 FR 6576, Feb. 11, 1994; 60 FR 63175, Dec. 8, 1995; 62 FR 46025, Aug. 29, 1997; 62 FR 59098, Oct. 31, 1997; 63 FR 35065, June 26, 1998]

### § 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.

*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