§ 422.350 Basis, scope, and definitions.

(a) Basis and scope. This subpart is based on sections 1851 and 1855 of the Act which, in part—
(1) Authorize provider sponsored organizations, (PSOs), to contract as an M+C plan;
(2) Require that a PSO meet certain qualifying requirements; and
(3) Provide for waiver of State licensure for PSOs under specified conditions.

(b) Definitions. As used in this subpart (unless otherwise specified)—

Capitation payment means a fixed per enrollee per month amount paid for contracted services without regard to the type, cost, or frequency of services furnished.

Cash equivalent means those assets excluding accounts receivable that can be exchanged on an equivalent basis as cash, or converted into cash within 90 days from their presentation for exchange.

Control means that an individual, group of individuals, or entity has the power, directly or indirectly, to direct or influence significantly the actions or policies of an organization or institution.

Current ratio means total current assets divided by total current liabilities.

Deferred acquisition costs are those costs incurred in starting or purchasing a business. These costs are capitalized as intangible assets and carried on the balance sheet as deferred charges since they benefit the business for periods after the period in which the costs were incurred.

Engaged in the delivery of health care services means—

(1) For an individual, that the individual directly furnishes health care services, or
(2) For an entity, that the entity is organized and operated primarily for the purpose of furnishing health care services directly or through its provider members or entities.

Generally accepted accounting principles (GAAP) means broad rules adopted by the accounting profession as guides in measuring, recording, and reporting the financial affairs and activities of a business to its owners, creditors and other interested parties.

Guarantor means an entity that—
(1) Has been approved by CMS as meeting the requirements to be a guarantor; and
(2) Obligates its resources to a PSO to enable the PSO to meet the solvency requirements required to contract with CMS as an M+C organization.

Health care delivery assets (HCDAs) means any tangible assets that are part of a PSO’s operation, including hospitals and other medical facilities and their ancillary equipment, and such property as may be reasonably required for the PSO’s principal office or for such other purposes as the PSO may need for transacting its business.

Insolvency means a condition in which the liabilities of the debtor exceed the fair valuation of its assets.

Net worth means the excess of total assets over total liabilities, excluding fully subordinated debt or subordinated liabilities.

Provider-sponsored organization (PSO) means a public or private entity that—
(1) Is established or organized, and operated, by a provider or group of affiliated providers;
(2) Provides a substantial proportion (as defined in §422.352) of the health care services under the M+C contract directly through the provider or affiliated group of providers; and
(3) When it is a group, is composed of affiliated providers who—
(i) Share, directly or indirectly, substantial financial risk, as determined under §422.356, for the provision of services that are the obligation of the PSO under the M+C contract; and
(ii) Have at least a majority financial interest in the PSO.

Qualified actuary means a member in good standing of the American Academy of Actuaries or a person recognized by the Academy as qualified for
membership, or a person who has otherwise demonstrated competency in the field of actuarial determination and is satisfactory to CMS.

Statutory accounting practices means those accounting principles or practices prescribed or permitted by the domiciliary State insurance department in the State that PSO operates.

Subordinated debt means an obligation that is owed by an organization, that the creditor of the obligation, by law, agreement, or otherwise, has a lower repayment rank in the hierarchy of creditors than another creditor. The creditor would be entitled to repayment only after all higher ranking creditors' claims have been satisfied. A debt is fully subordinated if it has a lower repayment rank than all other classes of creditors.

Subordinated liability means claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all other creditors.

Uncovered expenditures means those expenditures for health care services that are the obligation of an organization, for which an enrollee may also be liable in the event of the organization's insolvency and for which no alternative arrangements have been made that are acceptable to CMS. They include expenditures for health care services for which the organization is at risk, such as out-of-area services, referral services and hospital services. However, they do not include expenditures for services when a provider has agreed not to bill the enrollee.

§ 422.354 Requirements for affiliated providers.

A PSO that consists of two or more providers must demonstrate to CMS's satisfaction that it meets the following requirements:

(a) The providers are affiliated. For purposes of this subpart, providers are affiliated if, through contract, ownership, or otherwise—

(1) One provider, directly or indirectly, controls, is controlled by, or is under common control with another;

(2) Each provider is part of a lawful combination under which each shares substantial financial risk in connection with the PSO's operations;

(3) Both, or all, providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986; or

(4) Both, or all, providers are part of an affiliated service group under section 414 of that Code.
§ 422.356 Determining substantial financial risk and majority financial interest.

(a) Determining substantial financial risk. The PSO must demonstrate to CMS’s satisfaction that it apportions a significant part of the financial risk of the PSO enterprise under the M+C contract to each affiliated provider. The PSO must demonstrate that the financial arrangements among its affiliated providers constitute “substantial” risk in the PSO for each affiliated provider. The following mechanisms may constitute risk-sharing arrangements, and may have to be used in combination to demonstrate substantial financial risk in the PSO enterprise.

(1) Agreement by a provider to accept capitation payment for each Medicare enrollee.

(2) Agreement by a provider to accept as payment a predetermined percentage of the PSO premium or the PSO’s revenue.

(3) The PSO’s use of significant financial incentives for its affiliated providers, with the aim of achieving utilization management and cost containment goals. Permissible methods include the following:

(A) To cover losses of the PSO.

(B) To cover losses of other affiliated providers.

(C) To be returned to the affiliated provider if the PSO meets its utilization management or cost containment goals for the specified time period.

(D) To be distributed among affiliated providers if the PSO meets its utilization management or cost-containment goals for the specified time period.

(ii) Affiliated providers agree to preestablished cost or utilization targets for the PSO and to subsequent significant financial rewards and penalties (which may include a reduction in payments to the provider) based on the PSO’s performance in meeting the targets.

(4) Other mechanisms that demonstrate significant shared financial risk.

(b) Determining majority financial interest. Majority financial interest means maintaining effective control of the PSO.

§ 422.370 Waiver of State licensure.

For an organization that seeks to contract to offer an M+C plan under this subpart, CMS may waive the State licensure requirement of section 1855(a)(1) of the Act if—

(a) The organization requests a waiver no later than November 1, 2002; and

(b) CMS determines there is a basis for a waiver under §422.372.

§ 422.372 Basis for waiver of State licensure.

(a) General rule. Subject to this section and to paragraphs (a) and (e) of §422.374, CMS may waive the State licensure requirement if the organization has applied (except as provided in paragraph (b)(4) of this section) for the most closely appropriate State license or authority to conduct business as an M+C plan.

(b) Basis for waiver of State licensure. Any of the following may constitute a basis for CMS’s waiver of State licensure.

(1) Failure to act timely on application. The State failed to complete action on the licensing application within 90 days of the date the State received a substantially complete application.
(2) Denial of application based on discriminatory treatment. The State has—
   (i) Denied the license application on the basis of material requirements, procedures, or standards (other than solvency requirements) not generally applied by the State to other entities engaged in a substantially similar business; or
   (ii) Required, as a condition of licensure that the organization offer any product or plan other than an M+C plan.

(3) Denial of application based on different solvency requirements. (i) The State has denied the application, in whole or in part, on the basis of the organization’s failure to meet solvency requirements that are different from those set forth in §§ 422.380 through 422.390; or
   (ii) CMS determines that the State has imposed, as a condition of licensure, any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from those set forth by CMS to implement, monitor, and enforce §§ 422.380 through 422.390.

(4) State declines to accept licensure application. The appropriate State licensing authority has given the organization written notice that it will not accept its licensure application.

[63 FR 35098, June 26, 1998]

§ 422.374 Waiver request and approval process.

(a) Substantially complete waiver request. The organization must submit a substantially complete waiver request that clearly demonstrates and documents its eligibility for a waiver under § 422.372.

(b) CMS gives the organization written notice of granting or denial of waiver within 60 days of receipt of a substantially complete waiver request.

(c) Subsequent waiver requests. An organization that has had a waiver request denied, may submit subsequent waiver requests until November 1, 2002.

(d) Effective date. A waiver granted under § 422.370 will be effective on the effective date of the organization’s M+C contract.

(e) Consistency in application. CMS reserves the right to revoke waiver eligibility if it subsequently determines that the organization’s M+C application is significantly different from the application submitted by the organization to the State licensing authority.

[63 FR 25377, May 7, 1998, as amended at 63 FR 35098, June 26, 1998]

§ 422.376 Conditions of the waiver.

A waiver granted under this section is subject to the following conditions:

(a) Limitation to State. The waiver is effective only for the particular State for which it is granted and does not apply to any other State. For each State in which the organization wishes to operate without a State license, it must submit a waiver request and receive a waiver.

(b) Limitation to 36-month period. The waiver is effective for 36 months or through the end of the calendar year in which the 36 month period ends unless it is revoked based on paragraph (c) of this section.

(c) Mid-period revocation. During the waiver period (set forth in paragraph (b) of this section), the waiver is automatically revoked upon—
   (1) Termination of the M+C contract;
   (2) The organization’s compliance with the State licensure requirement of section 1855(a)(1) of the Act; or
   (3) The organization’s failure to comply with § 422.378.

[63 FR 25377, May 7, 1998]

§ 422.378 Relationship to State law.

(a) Preemption of State law. Any provisions of State law that relate to the licensing of the organization and that prohibit the organization from providing coverage under a contract as specified in this subpart, are superseded.

(b) Consumer protection and quality standards. (1) A waiver of State licensure granted under this subpart is conditioned upon the organization’s compliance with all State consumer protection and quality standards that—
   (i) Would apply to the organization if it were licensed under State law; or
   (ii) Generally apply to other M+C organizations and plans in the State; and
§422.380

(iii) Are consistent with the standards established under this part.

(2) The standards specified in paragraph (b)(1) of this section do not include any standard preempted under section 1856(b)(3)(B) of the Act.

(c) Incorporation into contract. In contracting with an organization that has a waiver of State licensure, CMS incorporates into the contract the requirements specified in paragraph (b) of this section.

(d) Enforcement. CMS may enter into an agreement with a State for the State to monitor and enforce compliance with the requirements specified in paragraph (b) of this section by an organization that has obtained a waiver under this subpart.

§422.380 Solvency standards.

General rule. A PSO or the legal entity of which the PSO is a component that has been granted a waiver under §422.370 must have a fiscally sound operation that meets the requirements of §§422.382 through 422.390.

§422.382 Minimum net worth amount.

(a) At the time an organization applies to contract with CMS as a PSO under this part, the organization must have a minimum net worth amount, as determined under paragraph (c) of this section, of:

(1) At least $1,500,000, except as provided in paragraph (a)(2) of this section.

(2) No less than $1,000,000 based on evidence from the organization’s financial plan (under §422.384) demonstrating to CMS’s satisfaction that the organization has available to it an administrative infrastructure that CMS considers appropriate to reduce, control or eliminate start-up administrative costs.

(b) After the effective date of a PSO’s M+C contract, a PSO must maintain a minimum net worth amount equal to the greater of—

(1) One million dollars;

(2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with CMS for up to and including the first $150,000,000 of annual premiums and 1 percent of annual premium revenues on premiums in excess of $150,000,000;

(3) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with CMS; or

(4) Using the most recent financial statement filed with CMS, an amount equal to the sum of—

(i) Eight percent of annual health care expenditures paid on a non-capped basis to non-affiliated providers; and

(ii) Four percent of annual health care expenditures paid on a capped basis to non-affiliated providers plus annual health care expenditures paid on a non-capped basis to affiliates.

(iii) Annual health care expenditures that are paid on a capped basis to affiliated providers are not included in the calculation of the net worth requirement (regardless of downstream arrangements from the affiliated provider) under paragraphs (a) and (b)(4) of this section.

(c) Calculation of the minimum net worth amount—(1) Cash requirement. (i) At the time of application, the organization must maintain at least $750,000 of the minimum net worth amount in cash or cash equivalents.

(ii) After the effective date of a PSO’s M+C contract, a PSO must maintain the greater of $750,000 or 40 percent of the minimum net worth amount in cash or cash equivalents.

(2) Intangible assets. An organization may include intangible assets, the value of which is based on Generally Accepted Accounting Principles (GAAP), in the minimum net worth amount calculation subject to the following limitations—

(i) At the time of application. (A) Up to 20 percent of the minimum net worth amount, provided at least $1,000,000 of the minimum net worth amount is met through cash or cash equivalents; or

(B) Up to 10 percent of the minimum net worth amount, if less than $1,000,000 of the minimum net worth amount is met through cash or cash equivalents; or
equivalents, or if CMS has used its discretion under paragraph (a)(2) of this section.

(ii) From the effective date of the contract. (A) Up to 20 percent of the minimum net worth amount if the greater of $1,000,000 or 67 percent of the minimum net worth amount is met by cash or cash equivalents; or

(B) Up to ten percent of the minimum net worth amount if the greater of $1,000,000 or 67 percent of the minimum net worth amount is not met by cash or cash equivalents.

(3) Health care delivery assets. Subject to the other provisions of this section, a PSO may apply 100 percent of the GAAP depreciated value of health care delivery assets (HCDAs) to satisfy the minimum net worth amount.

(4) Other assets. A PSO may apply other assets not used in the delivery of health care provided that those assets are valued according to statutory accounting practices (SAP) as defined by the State.

(5) Subordinated debts and subordinated liabilities. Fully subordinated debt and subordinated liabilities are excluded from the minimum net worth amount calculation.

(6) Deferred acquisition costs. Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

§ 422.384 Financial plan requirement.

(a) General rule. At the time of application, an organization must submit a financial plan acceptable to CMS.

(b) Content of plan. A financial plan must include—

(1) A detailed marketing plan;

(2) Statements of revenue and expense on an accrual basis;

(3) Cash-flow statements;

(4) Balance sheets;

(5) Detailed justifications and assumptions in support of the financial plan including, where appropriate, certification of reserves and actuarial liabilities by a qualified actuary; and

(6) If applicable, statements of the availability of financial resources to meet projected losses.

(c) Period covered by the plan. A financial plan must—

(1) Cover the first 12 months after the estimated effective date of a PSO’s M+C contract; or

(2) If the PSO is projecting losses, cover 12 months beyond the end of the period for which losses are projected.

(d) Funding for projected losses. Except for the use of guarantees, LOC, and other means as provided in § 422.384(e), (f) and (g), an organization must have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the PSO’s financial plan.

(e) Guarantees and projected losses. Guarantees will be an acceptable resource to fund projected losses, provided that a PSO—

(1) Meets CMS’s requirements for guarantors and guarantee documents as specified in § 422.390; and

(2) Obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows—

(i) Prior to the effective date of a PSO’s M+C contract, the amount of the projected losses for the first two quarters;

(ii) During the first quarter and prior to the beginning of the second quarter of a PSO’s M+C contract, the amount of projected losses through the end of the third quarter; and

(iii) During the second quarter and prior to the beginning of the third quarter of a PSO’s M+C contract, the amount of projected losses through the end of the fourth quarter.

(3) If the guarantor complies with the requirements in paragraph (e)(2) of this section, the PSO, in the third quarter, may notify CMS of its intent to reduce the period of advance funding of projected losses. CMS will notify the PSO within 60 days of receiving the PSO’s request if the requested reduction in the period of advance funding will not be accepted.

(4) If the guarantee requirements in paragraph (e)(2) of this section are not met, CMS may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. CMS retains discretion to require other methods or timing of funding, considering factors such as...
§ 422.386 Liquidity.

(a) A PSO must have sufficient cash flow to meet its financial obligations as they become due and payable.

(b) To determine whether the PSO meets the requirement in paragraph (a) of this section, CMS will examine the following—

1. The PSO’s timeliness in meeting current obligations;
2. The extent to which the PSO’s current ratio of assets to liabilities is maintained at 1:1 including whether there is a declining trend in the current ratio over time; and
3. The availability of outside financial resources to the PSO.

(c) If CMS determines that a PSO fails to meet the requirement in paragraph (b)(1) of this section, CMS will require the PSO to initiate corrective action and pay all overdue obligations.

(d) If CMS determines that a PSO fails to meet the requirement of paragraph (b)(2) of this section, CMS may require the PSO to initiate corrective action to—

1. Change the distribution of its assets:
   - Reduce its liabilities; or
   - Make alternative arrangements to secure additional funding to restore the PSO’s current ratio to 1:1.

(e) If CMS determines that there has been a change in the availability of outside financial resources as required by paragraph (b)(3) of this section, CMS requires the PSO to obtain funding from alternative financial resources.


§ 422.388 Deposits.

(a) Insolvency deposit. (1) At the time of application, an organization must deposit $100,000 in cash or securities (or any combination thereof) into an account in a manner that is acceptable to CMS.

(2) The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.

(3) At the time of the PSO’s application for an M+C contract and, thereafter, upon CMS’s request, a PSO must provide CMS with proof of the insolvency deposit, such proof to be in a form that CMS considers appropriate.


§ 422.386 Liquidity.

(f) Letters of credit. Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to CMS. They must be capable of being promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.

(g) Other means. If satisfactory to CMS, and for periods beginning one year after the effective date of a PSO’s M+C contract, a PSO may use the following to fund projected losses—

1. Lines of credit from regulated financial institutions;
2. Legally binding agreements for capital contributions; or
3. Legally binding agreements of a similar quality and reliability as permitted in paragraphs (g)(1) and (2) of this section.

(h) Application of guarantees, Letters of credit or other means of funding projected losses. Notwithstanding any other provision of this section, a PSO may use guarantees, letters of credit and, beginning one year after the effective date of a PSO’s M+C contract, other means of funding projected losses, but only in a combination or sequence that CMS considers appropriate.

(4) If a PSO is not otherwise required

 to file a quarterly report, it must file a

 report within 45 days of the end of the

 calendar quarter with information suf-

 ficient to demonstrate compliance with

 this section.

 (5) The deposit required under this

 section is restricted and in trust for

 CMS’s use to protect the interests of

 the PSO’s Medicare enrollees and to

 pay the costs associated with admin-

 istering the insolvency. It may be used

 only as provided under this section.

 (c) A PSO may use the deposits re-

quired under paragraphs (a) and (b) of

this section to satisfy the PSO’s min-

imum net worth amount required

under §422.382(a) and (b).

(d) All income from the deposits or

trust accounts required under para-

graphs (a) and (b) of this section, are

considered assets of the PSO. Upon

CMS’s approval, the income from the

deposits may be withdrawn.

(e) On prior written approval from

CMS, a PSO that has made a deposit

under paragraphs (a) or (b) of this sec-

tion, may withdraw that deposit or any

part thereof if—

(1) A substitute deposit of cash or se-

curities of equal amount and value is

made;

(2) The fair market value exceeds the

amount of the required deposit; or

(3) The required deposit under para-

graphs (a) or (b) of this section is re-

duced or eliminated.

§422.390 Guarantees.

(a) General policy. A PSO, or the legal

entity of which the PSO is a compo-

nent, may apply to CMS to use the fi-

nancial resources of a guarantor for

the purpose of meeting the require-

ments in §422.384. CMS has the discre-

tion to approve or deny approval of the

use of a guarantor.

(b) Request to use a guarantor. To

apply to use the financial resources of

a guarantor, a PSO must submit to

CMS—

(1) Documentation that the guar-

antor meets the requirements for a

guarantor under paragraph (c) of this

section; and

(2) The guarantor’s independently au-

dited financial statements for the cur-

cent year-to-date and for the two most

recent fiscal years. The financial state-

ments must include the guarantor’s bal-

cance sheets, profit and loss state-

ments, and cash flow statements.

(c) Requirements for guarantor. To

serve as a guarantor, an organization

must meet the following requirements:

(1) Be a legal entity authorized to

conduct business within a State of the

United States.

(2) Not be under Federal or State

bankruptcy or rehabilitation pro-

ceedings.

(3) Have a net worth (not including

other guarantees, intangibles and re-

stricted reserves) equal to three times

the amount of the PSO guarantee.

(4) If the guarantor is regulated by a

State insurance commissioner, or other

State official with authority for risk-

bearing entities, it must meet the net

worth requirement in §422.390(c)(3)

with all guarantees and all invest-

ments in and loans to organizations

covered by guarantees excluded from

its assets.

(5) If the guarantor is not regulated

by a State insurance commissioner, or

other similar State official it must

meet the net worth requirement in

§422.390(c)(3) with all guarantees and

all investments in and loans to organi-

zations covered by a guarantee and to

related parties (subsidiaries and affili-

ates) excluded from its assets.

(d) Guarantee document. If the guar-

antee request is approved, a PSO must

submit to CMS a written guarantee
document signed by an appropriate au-

thority of the guarantor. The guar-

antee document must—

(1) State the financial obligation cov-

ered by the guarantee;

(2) Agree to—

(i) Unconditionally fulfill the finan-

cial obligation covered by the guar-

antee; and

(ii) Not subordinate the guarantee to

any other claim on the resources of the

guarantor;

(3) Declare that the guarantor must

act on a timely basis, in any case not

more than 5 business days, to satisfy

the financial obligation covered by the

guarantee; and

(4) Meet other conditions as CMS

may establish from time to time.
§ 422.400 Reporting requirement.

A PSO must submit to CMS the current internal financial statements and annual audited financial statements of the guarantor according to the schedule, manner, and form that CMS requests.

(f) Modification, substitution, and termination of a guarantee. A PSO cannot modify, substitute or terminate a guarantee unless the PSO—

(1) Requests CMS’s approval at least 90 days before the proposed effective date of the modification, substitution, or termination;

(2) Demonstrates to CMS’s satisfaction that the modification, substitution, or termination will not result in insolvency of the PSO; and

(3) Demonstrates how the PSO will meet the requirements of this section.

(g) Nullification. If at any time the guarantor or the guarantee ceases to meet the requirements of this section, CMS will notify the PSO that it ceases to recognize the guarantee document. In the event of this nullification, a PSO must—

(1) Meet the applicable requirements of this section within 15 business days; and

(2) If required by CMS, meet a portion of the applicable requirements in less than the time period granted in paragraph (g)(1) of this section.

[63 FR 25379, May 7, 1998]

Subpart I—Organization Compliance With State Law and Preemption by Federal Law

SOURCE: 63 FR 35099, June 26, 1998, unless otherwise noted.

§ 422.400 State licensure requirement.

Except in the case of a PSO granted a waiver under subpart H of this part, each M+C organization must—

(a) Be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity (as defined in §422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more M+C plans;

(b) If not commercially licensed, obtain certification from the State that the organization meets a level of financial solvency and such other standards as the State may require for it to operate as an M+C organization; and

(c) Demonstrate to CMS that—

(1) The scope of its license or authority allows the organization to offer the type of M+C plan or plans that it intends to offer in the State; and

(2) If applicable, it has obtained the State certification required under paragraph (b) of this section.

§ 422.402 Federal preemption of State law.

(a) General preemption. Except as provided in paragraph (b) of this section, the rules, contract requirements, and standards established under this part supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to M+C organizations and their M+C plans only to the extent that such State laws are inconsistent with the standards established under this part. This preemption of State laws and other standards applies only to coverage pursuant to an M+C contract, and does not extend to benefits outside of such contract or to individuals who are not M+C enrollees of an organization with an M+C contract.

(b) Specific preemption. As they might otherwise apply to the M+C plans of an M+C organization in a State, State laws and regulations pertaining to the following areas are specifically preempted by this part:

(1) Benefit requirements, such as mandating the inclusion in an M+C plan of a particular service, or specifying the scope or duration of a service (for example, length of hospital stay, number of home health visits). State cost-sharing standards with respect to any benefits are preempted only if they are inconsistent with this part, as provided for in paragraph (a) of this section.

(2) Requirements relating to inclusion or treatment of providers and suppliers.

(3) Coverage determinations (including related appeal and grievance processes for all benefits included under an M+C contract). Determinations on issues other than whether a service is covered under an M+C contract, and the extent of enrollee liability under the M+C plan for such a service, are