DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

JAN 2 2 2019

Jonathan Bick
Director
Division of Health Plan Contracting and Oversight
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP - 1211)
Albany, NY 12237

Dear Mr. Bick:

Thank you for your response to our December 7, 2018 letter requesting additional information (RAI) for New York State Department of Health's proposed addition of the Children and Family Treatment and Support Services (CFTSS) to the Medicaid Managed Care (MMC) benefit package under your state's "Medicaid Redesign Team" (MRT) section 1115(a) demonstration (Project Number 11-W-001142/2). The Centers for Medicare & Medicaid Services (CMS) received your letter on January 2, 2019 and we appreciate the updates regarding submission of State Plan Amendment #19-0003, managed care plan readiness reviews and other information provided in your response. Based on the information provided to our RAI and, in accordance with section V, Special Term and Condition (STC) 6(c), CMS hereby approves implementation of the benefit transition and we will post this correspondence on Medicaid.gov.

We look forward to continuing work with you and your staff on implementation of the MRT demonstration in New York State. If you have additional questions or concerns, please contact your CMS project officer, Ms. Audrey Cassidy at (410) 786-0059 or at Audrey.Cassidy@cms.hhs.gov. Official communication regarding MMC benefit package matters should be simultaneously sent to Ms. Cassidy and to the CMS New York Region state lead for managed care, Ms. Suzanne Gallagher at (212) 616-2482 or at Suzanne.Gallagher@cms.hhs.gov.

Sincerely,

Judith Cash
Director
State Demonstrations Group

cc: Ricardo Holligan, Acting Associate Regional Administrator, CMS New York Region
Maria Tabakov, State Lead, CMS New York Region
Suzanne Gallagher, State Lead for Managed Care, CMS New York Region
Audrey Cassidy, Project Officer, CMS Central Office

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 2, 2019

Judith Cash
Acting Director
State Demonstrations Group
Centers for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Cash:

This correspondence is in response to your December 7, 2018 letter requesting additional information for the New York State Department of Health's (the Department) proposal to add Children Treatment and Family and Support Services to the Medicaid Managed Care benefit package.

The Department is submitting State Plan Amendment (SPA)# 19-0003 with the correct timeline for implementation of the Children and Family Treatment and Support Services (CFTSS). The Department notes that the three services being offered January 1, 2019: Other Licensed Practitioners (OLP), Community Psychiatric Supports and Treatment (CPST), and Psychosocial Rehabilitation (PSR) are already covered by Early Periodic Screening and Diagnostic Testing (EPSDT) per 42 CFR Part 441, subpart B. Medically necessary EPSDT is a covered benefit in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract) and is provided to enrolled children. Through the SPA, the Department is confirming New York State (the State) requirements for CFTSS providers and setting rates for OLP, CPST and PSR.

Attached are the managed care plan readiness review materials and schedule for implementation of the OLP, CPST, and PSR requirements by the managed care organizations, as follows:

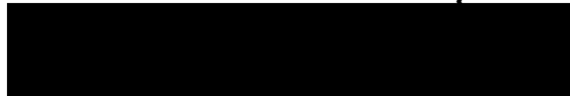
- Attachment 1: Additional information, readiness review materials, Narrative.pdf. This file describes the phased in approach for confirming plan readiness in accordance with the Medicaid Managed Care Organization Children's Medicaid System Transformation Requirements and Standards, issued July 31, 2017, as amended May 15, 2018. The CFTSS portion of this readiness plan was included in phase 1 and phase 2. Phase 1 began October 31, 2017, with desk review of the application submissions, and includes desk review of monthly activity submissions, which began July 15, 2018, and will continue until full implementation. Phase 2 included on-site reviews held in December 2018. Phase 3 is future planned activity to confirm readiness for other portions of the Children's Medicaid Systems Transformation, including provision of aligned children's Home and Community Based Services (HCBS) under the consolidated 1915(c) waiver and concurrent 1115 waiver amendment, as under review by CMS.

- Attachment 2: Additional information, readiness review materials, 2018-10-25 Claims-IT Demonstration Schedule
- Attachment 3: Additional information, readiness review materials, 2018-12-3 Children's Claims-IT Review Detailed Agenda
- Attachment 4: Additional information, readiness review materials, NYS Children's MC Standards Section 4.0 Offsite Review Tool 7-31-2017. Note, this tool was designed to track readiness for the Children's Medicaid System Transformation; not all portions of this tool are directly related to readiness for CFTSS.

The current, approved Model Contract permits the State to modify the benefit package under Section 4.3 upon sixty days' notice to the managed care plans. The Department provided such notice on November 2, 2018. No contract changes are required for implementation of EPSDT services and CFTSS. Currently, the Department is negotiating the new model contract (effective 3/1/19) with the health plans. There are currently no changes being made to language related to EPSDT. The Department anticipates submitting the new model contract to CMS for approval in late January/early February 2019. Given that EPSDT services are already included in the Medicaid managed care benefit package, any rate adjustments will be reflected in the April 2019 rate package.

If you have any questions regarding the State's inclusion of CFTSS in the Medicaid Managed Care benefit package, please contact Ms. Patricia Sheppard of my staff at (518) 473-1134, or by email at patricia.sheppard@health.ny.gov.

Sincerely,



Jonathan Bick
Director
Division of Health Plan Contracting and Oversight
Office of Health Insurance Programs

Attachments

cc: Audrey Cassidy, NY's CMS Project Officer
Adam Goldman (CMS)
Maria Tabakov (CMS)
David Amedio (CMS)
Nicole McKnight (CMS)
Christopher Semidey (CMS)
Phil Alotta (NYSDOH)
Priscilla Smith (NYSDOH)
Hope Goldhaber (NYSDOH)
Patricia Sheppard (NYSDOH)

Attachment 1

MCO Readiness Reviews have been organized into three phases to ensure MCOs are prepared to comply with the Children's Standards.

Phase 1: Ongoing Desk Reviews

- Document review of all Policies and Procedures, Medical Necessity Criteria, Recruitment and Training, Network Development. This is an iterative process leading up to and through implementation.
- This helps the State team focus on issues that need to be looked at during the onsite review.

Phase 2: December 2018

Claims/IT Readiness Review

- Confirm that MCOs are prepared to adjudicate claims for the three Children and Family Treatment and Support Services going live on January 1, 2019 including:
    - Other Licensed Practitioner (OLP)
    - Community Psychiatric Support and Treatment (CPST)
    - Psychosocial Rehabilitation Services (PSR)
- The State will conduct a review of the following areas:
    - Adequate systems configurations to pay claims as outlined in the NYS Children's Billing Manual
    - Provider testing of claims submissions
    - Providers are accurately loaded in the system
    - Review of provider portals

Phase 3: TBD 2019

Comprehensive Program, Claims and IT Onsite Readiness Review

Confirm MCO ability to administer services moving into managed care according to the Children's Systems Transformation timeline. This includes:

- Interviews with Plan leadership, Utilization Management and Clinical Management staff, Member Services, Foster Care Liaison and Liaison for Medically Fragile Children
- Establishment of appropriate children's committees including the children's advisory committee
- Care Management and Authorization systems demonstrations
- IT and Billing Systems
    - Status of IT Systems Configurations
    - Claims system:
        - Submission of claims
        - Web portal demonstration
        - Network development

The documents we use to support this process are outlined below and attached:

1- NYS Children's MC Standards Offsite Review Tool

   a. All 18 MCOs received this tool to demonstrate that internal documents have been updated to comply with the requirements set forth in the Children's MCO Standards located on the DOH website (https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf).

2- Claims IT Reviews for January 2019 carve-in

   a. Claims IT Demonstration Schedule

      i. NYS is in the midst of an intensive Claims/ IT readiness reviews across all MCOs. The purpose of this review is to determine MCO preparedness to pay claims submitted for OLP, CPST, PSR services rendered.

b. Claims IT Review Detailed Agenda
   i. This agenda outlines key areas under review with MCOs including any outstanding issues from desk review, systems configuration workplan updates and systems demonstrations.

Onsite Readiness Review

r 2018

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
3	4	5	6	
Emblem 55 Water Street New York, NY 10041 9am-12pm **MetroPlus** 160 Water Street New York, NY 10038 1pm-4pm 10	**AmidaCare** 14 Penn Plaza 2nd Floor New York, NY 10122 9am-12pm **Crystal Run** 109 Rykoski Lane Middletown NY, 10941 1pm-4pm 11	**Affinity** 1776 Eastchester Road, Bronx, NY 10461 9am-12pm **VNSNY** 1250 Broadway 26th Floor New York, NY 10001 1pm-4pm 12	**MVP** 625 State Street Schenectady, NY 12305 9am-12pm **IHA** 511 Farber Lakes Drive, Williamsville, NY 14221 1pm-4pm 13	**YourCare** 1120 Pittsford-Victor Rd Pittsford, NY 14534 9am-12pm **C** 500 Pa Blvd 1p
HealthNow 257 West Genesee Street Buffalo, NY 14202 9am-12pm **Molina** 5232 Witz Drive North Syracuse, NY 13212 1pm-4pm 17	**HealthPlus** 9 Pine Street 14th Floor, New York, NY 10005 9am-12pm **Excellus** Court Street, Rochester, New York 14647 1pm-4pm 18	**Fidelis** 95-25 Queen Blvd 8th Floor Rego Park, NY 11374 9am-12pm **HealthFirst** 100 Church Street 8th Floor New York, NY 10007 1pm-4pm 19	**WellCare** One New York Plaza New York, New York 10004 9am-12pm **United** 77 Water Street 14th Floor New York, NY 10005 1pm-4pm 20	
24	25	26	27	

New York State Children's System Webinar Readiness Review Agenda

Information Systems, Claims and Reporting for Information Systems, Claims and Reporting for Other Licensed Practitioner (OLP), Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation Services (PSR)

9:00 am -11:00 am or 1:00 pm- 3:00 pm (approx. 2 hours)

Who:

Plan management including:

Information Systems (IS)
Project Manager
Claims Manager
Government Liaison
Provider Relations Manager
Provider Registry Manager

What:

- NYS overview of systems demonstration and purpose
- Plan must be prepared to review children's services systems (claims, website, IT) work plan and other relevant documents, including the following:
  - Claims processing policies and procedures.
  - Detailed workplan tasks and due dates. For example: eligibility loads, benefit package configuration, data sharing with vendors, report development, provider loads, system testing, website updates, web portal functionality, etc.
  - Outstanding items from Children's readiness review.
- Interview and online system demo with IS:
  - Status of data load for new provider types/specialties for the services effective January 1, 2019:
    - Review of contracted providers to verify the following is accurately loaded:
      - Provider name/address/NPI
      - Site level details including all providers under that agency
      - Rate/procedure codes and modifiers for contracted services
      - Fee schedules
  - Status of claims testing with providers.
  - Review of sample member benefit file to ensure the inclusion of the 3 new CFTSS services.
  - Status of website and member/provider portal updates to reflect new providers and informational materials related to the Children's carve-in.
  - Claims denial intervention activities and provider technical assistance efforts
  - Review of sample monitoring reports that may include:
    - Number of claims denied broken out by service type/ rate code and reason
    - Number of claims denied and/or reprocessed by provider in order of magnitude
    - Complaints, resolution status, and technical assistance provided to BH providers

Provider Manual Checklist

Instructions:
In the space provided, identify where each required element is addressed in the provider manual, in an addendum to the provider manual or within the provider contract. Upload completed checklist to Mercer Connect (Network Section- Provider Manual sub-folder) with a copy of the provider manual, provider manual addendum, and representative provider contract.

Requirement	Citation	Document and Location
PROVIDER RESPONSIBILITIES		
Include the standards for appointment availability and appointment waiting times. Include the standards for appointment availability and appointment waiting times for the specific children's specialty services.	Table 6. Appointment Availability Standard by Service Type	
Include the timeframes for completion of required foster care initial health assessments as described in Table 7. A series of assessments, as outlined in Table 7, provides a complete picture of the foster care child's health needs and is the basis for developing a comprehensive POC.	Section 3.4 M. iv. Table 7: Foster Care Initial Health Services	
The Plan shall comply with State Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. Specifically, Plans must incorporate the following into their guidance: i. OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html) ii. OASAS Clinical Guidance: (https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm) iii. OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf) iv. OCFS Working Together: Health Services for Children/Youth in Foster Care Manual (http://ocfs.ny.gov/main/sppd/health_services/manual.asp) v. OHIP Principles for Medically Fragile Children (Attachment G)	Section 3.8 L.	
D. COVERED AND NON-COVERED SERVICES		
Details of the benefits covered by the MCO.	Refer to Table 2: Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21 Included in the Children's System Transformation Transition	
ACCESS TO SPECIALTY CARE		

Requirement	Citation	Document and Location
The Plan must contract with providers who have expertise in caring for medically fragile children, to ensure that medically fragile children, including children with cooccurring developmental disabilities, receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the Plan for out-of-network providers when participating providers cannot meet the child's needs. Details the MCO's process to request a referral to an out-of-network provider when: (a) a network does not include an available provider with the appropriate training and experience to meet the needs of the members. (b) medically necessary services are not available through network providers. The Plan must authorize services in accordance with established timeframes in the Medicaid Managed Care Model Contract; OHIP Principles for Medically Fragile Children (Attachment G); under EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning.	See Section 3.4D a) PHL 4403.6(a) Reg. 98-1.13(a), (h) b) PHL 4403.6(a),98.1.13(a)	
Description of referral process for HCBS and HCBS eligibility assessment.	Section 3.1 F. Section 3.6 E	
Mechanisms to obtain information from Health Home and HCBS providers, and report such information and related analytical data to evaluate the Enrollee's level of care; adequacy of service plans; provider qualifications; Enrollee health and safety; financial accountability and compliance, etc.	Section 3.1 F. Section 3.6 E	
If an enrolled child in foster care is placed in another county, and the Plan in which he or she is enrolled operates in the new county, the Plan must allow for the child to transition to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.	Section 3.4J	
If an enrolled child in foster care is placed outside of the Plan's service area, the plan must permit the enrollee to access providers with expertise treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.	Section 3.4K	
CONTINUITY OF CARE		
For continuity of care purposes the Plan must allow children to continue with their care providers, including medical, BH and HCBS providers, for a continuous Episode of Care. This requirement will be in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.	Section 3.5 G.	
To preserve continuity of care, children enrollees will not be required to change Health Homes or their Health Home Care Management Agency at the time of the transition. The Plan will be required to pay on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with the Plan.	Section 3.5 H.	
UTILIZATION REVIEW/ACTIONS		

Requirement	Citation	Document and Location
Includes the MCO's UR policies and procedures for BH benefits, LTSS and HCBS, including P&Ps and guidelines that comply with the following requirements: i. UM protocols, MNC guidelines, and Admission/ Service authorization criteria shall be specific to NYS for BH and HCBS benefits as appropriate and as defined in Table 2 consistent with State guidance. ii. OASAS will identify the guidelines that all Plans must use for SUD services. The LOCADTR 3.0 tool will be used for making prior authorization and continuing care decisions for all SUD services. The provider manual must include: (a) The process to obtain authorization for services and (b) A listing of services which require authorization by the MCO. (c) The MCO's definition of Medical Necessity. For Medicaid must use definition in Medicaid contract. (d) The circumstances under which utilization review will be undertaken – pre-authorization, concurrent, and retrospective reviews. (e) If UR is delegated to MSO, UR agent's process must be stated	Section 3.8. G. i. and ii. PHL 4902.1(b) Reg. 98-1.6(f) MMC/FHP Contract Section 1	
Includes the Plan's review process for HCBS review and approval of a POC inclusive of HCBS. a. HCBS must be managed in compliance with CMS HCBS Final Rule and any applicable State guidance. b. The Plan must ensure that the POC was developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs. c. The Plan must ensure HCBS is authorized pursuant to a POC. d. The Plan shall develop a data driven approach to identify service utilization patterns that deviate from any approved POC, conduct outreach to review such deviations, and require appropriate adjustments to either service delivery or the POC.	Section 3.8 G. iv.	
For children transitioning from a 1915(c) waiver, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC is to be developed. a. During the initial 180 days of the transition, the Plan will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review.	Section 3.8 G. v.	
For 24 months from the date of transition of the children's specialty services carve-in, for FFS children in receipt of HCBS at the time of enrollment, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC is to be developed.	Section 3.8 G. vi.	

Requirement	Citation	Document and Location
To facilitate a smooth transition of HCBS and LTSS authorizations, for children in receipt of HCBS, the Plan will begin accepting POCs: a. On May 1, 2018 for 1) their enrolled population or 2) a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed; and b. On November 1, 2018, for a child in the care of a LDSS/licensed VFCA, where Plan election has been confirmed by the LDSS/VFCA. c. The Plan will continue to accept POCs for children in receipt of HCBS in advance of the effective date of enrollment when the Plan is notified by another Plan, a Health Home Care Manager or the Independent Entity that there is consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed, or for a child in the care of a LDSS/licensed VFCA, Plan selection has been confirmed by the LDSS/VFCA.	Section 3.8 G. vii.	
APPEAL OF UTILIZATION REVIEW DECISIONS		
In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist). In addition: i. A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21. ii. A physician certified in addiction treatment must review all inpatient LOC/continuing stay denial for SUD treatment. iii. Any appeal of a denied BH medication for a child should be reviewed by a board certified child psychiatrist. iv. A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver.	Section 3.8 N.	
Quality Assurance		
Description of the MCO's quality assessment organizational arrangements and ongoing procedures.The Plan shall amend its quality assurance program to address specific monitoring requirements related to the populations, benefits and services covered in the Children's System Transformation Requirements and Standards document. [May be distributed as a separate document to providers]	Section 3.11 A. Reg. 98-1.12(e) MMC/FHP Contract 16.1	
Description of the MCO's Behavioral Health Quality Management Committee which expands existing QM committee and BH QM sub-committee functions to meet the quality requirements and standards for the populations, benefits and services for children as described in the Children's System Transformation Requirements and Standards Document including: i. The Plan maintains an active BH QM sub-committee which shall be expanded to include, in an advisory capacity, members, family members, youth and family peer support specialists, and child-serving providers. The BH QM sub-committee shall be responsible for carrying out the planned quality activities under the standards within this document related to individuals with BH conditions who access BH benefits and/or HCBS.	Section 3.11 B. MMC/FHP Contract 16.1(c)(ii)	

Requirement	Citation	Document and Location
State-designation of providers will suffice for the Plan's credentialing process. When contracting with NYS-designated providers, the Plan may not separately credential individual staff members in their capacity as employees of these programs. The Plan must still conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. The Plan shall still collect and accept program integrity related information from these providers, as required in the Medicaid Managed Care Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.	Section 3.6 C. MMC/FHP Contract 21.4 (b)	
MCO plan for provider education and training requirements shall reflect the expanded children's benefit and populations. The plan shall include an initial orientation and training to be offered to all providers in the Plan's network. i. Training and technical assistance shall be provided to the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, and UM requirements. ii. Training shall include processes for assessment for HCBS eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and POC development and review.	Section 3.7 A. and B.	
The manual shall provide information on the Plan's definitive strategies to promote BH-medical integration for children, including at-risk populations defined by the State. Considerations include: i. Provider access to rapid consultation from child and adolescent psychiatrists; ii. Provider access to education and training; and iii. Provider access to referral and linkage support for child and adolescent patients.	Section 3.9 E.	
Provider Payment		
The Plan shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan must pay at least the FFS fee schedule for 24 months for all SCAs.	Section 3.5 B.	
The Plan must pay at least the Medicaid FFS fee schedule for 24 months or as long as New York State mandates (whichever is longer) for the following services/providers: i. New EPSDT SPA services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports ii. OASAS clinics (Article 32 certified programs) iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs) iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)	Section 3.5 C.	

Requirement	Citation	Document and Location
Providers who historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide Care Management services that are being transitioned to Health Home, may receive a transitional rate for no more than 24 months. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.	Section 3.5 D.	
The Plan will be required to contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.	Section 3.5 E.	
The Plan shall ensure that all HCBS will be paid according to the NYS fee schedule as long as the Plan is not at risk for the service costs (e.g., for at least two years or until HCBS are included in the capitated rates).	Section 3.5 F.	