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Case 19-1022

SUPREME COURT OF TEXAS

In re
K & L AUTO CRUSHERS, LLC
THOMAS GOTHARD, JR.
Relators

Original Proceeding from the
160th Judicial District Court of Dallas County, Texas
Hon. Aiesha Redmond, Presiding
Trial Court Cause No. DC-18-07502

AMICUS CURIAE BRIEF OF RESEARCH AND PLANNING CONSULTANTS ON HEALTHCARE PAYMENT DATA

P.M. Schenkkan
State Bar No. 17741500
Matthew Baumgartner
State Bar No. 24062605
Graves Dougherty Hearon & Moody, P.C.
401 Congress Ave., Suite 2700
Austin, Texas 78701
(512) 480-5673 (telephone)
(512) 480-5873 (facsimile)
pschenkkan@gdhm.com
mbaumgartner@gdhm.com

ATTORNEYS FOR AMICUS CURIAE
RESEARCH AND PLANNING CONSULTANTS, L.P.

IDENTITY OF AMICUS CURIAE AND COUNSEL

Amicus Curiae and its counsel are:

Amicus Curiae:	Research and Planning Consultants, L.P.
Counsel for Amicus Curiae:	P. M. Schenkkan Matthew Baumgartner Graves Dougherty Hearon & Moody, PC

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STATEMENT OF INTEREST

Amicus curiae Research and Planning Consultants, L.P. (RPC) will pay for this brief. Ronald T. Luke, J.D., Ph.D., its owner, is a healthcare economist with 40 years of experience in Texas healthcare markets.

Dr. Luke chairs the Health Policy Committee of the Texas Association of Business. Appointed by Governor Bush as an original member of the Texas Healthcare Information Council, he played a major role in developing the Texas hospital discharge data system. Governor Perry appointed him to the Texas Health & Human Services Council, which supervises Texas Medicaid and CHIP, and to the Texas Institute for Healthcare Quality and Efficiency.

RPC analyzes healthcare charges and payments for providers and payors. It determines usual, customary, and reasonable charges and reasonable payments in personal injury and commercial litigation and in administrative proceedings. It comments on proposed agency rules setting payment amounts. It assists providers in establishing chargemasters. Dr. Luke and his colleagues know what data on healthcare charges and payments are available from public sources and what data are not. RPC hopes this information will be of value to the Court in deciding the scope of discovery of health care expenses in personal injury litigation.

INTRODUCTION AND SUMMARY

Research and Planning Consultants, L.P. (RPC) submitted amicus briefs[1] on healthcare payments in *In re North Cypress Med. Ctr. Operating Co.*, 559 S.W.3d 128 (Tex. 2018). RPC files this amicus brief to discuss two new and important federal laws: (1) CMS's *Price Transparency Rule,*[2] which requires hospitals to disclose payments from all sources, including in-network contracts, *see Am. Hosp. Ass'n v. Azar*, 983 F.3d 528 (D.C. Cir. 2020) (upholding rule); and (2) The *No Surprises Act,* included in the stimulus legislation signed into law on Dec. 27, 2020,[3] which regulates out-of-network payments to hospitals and professionals based on the median of the payor's in-network contract prices.

RPC respectfully submits this amicus brief to show the Court:

1. The new federal laws focus on network rates between insurers and providers, which have often occasioned trade secret disputes. As to hospitals, CMS's Price Transparency Rule makes these negotiated rates public, greatly weakening any argument for trade secret protection.

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[1] *See* Post-Submission Brief on "Reasonable Charge" Law and Facts (12/14/2017) and Brief Opposing Motion for Rehearing with Healthcare Payment Facts (7/16/2018).

[2] *See* 84 FR 65524-01, 2019 WL 6324858 (November 27, 2019).

[3] The Consolidated Appropriations Act, 2021, Public Law No: 116-260 (12/27/2020), not yet available on Congress.gov. The full text of the Enrolled Bill is available here: https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf (visited 1/27/2021).

2. Both new federal laws underscore the importance of knowing network rates in resolving payment disputes. This is especially important as to healthcare services provided under letters of protection in personal injury cases, for two reasons:

(a) No public database in Texas publishes the negotiated rates of commercial insurers and employer-sponsored (ERISA) plans by provider for all services;

(b) No public database in Texas publishes the negotiated rates of Medicare and Medicaid managed care organizations by provider for all services;

It is particularly important in this case to require the hospital to disclose its network payment rates *and its* acquisition cost for surgical implants: Its charges for implants account for most of its total charges, and the hospital's mark-up over the cost of the implants it bought from a vendor is likely to be unreasonable.

ARGUMENT

As discussed in *North Cypress* and in *Azar*, hospital charges are unregulated, arbitrary, not binding on patients or payors on their behalf, and untethered either to the payments the hospital receives or to its costs.[4] Such charges therefore do not automatically constitute the medical damages or reasonable payment amount Texas courts must enforce.

St. Camillus charged $528,568 for implants, nearly 80% of its total charges of $662,333. Those implant charges likely result from extreme markups above its invoice costs. When finding medical damages, the jury should know the actual invoice costs and the mark-up. Without discovery, the jury will not know those facts.

For hospital services, as opposed to implants, there are no invoice costs. The payments a hospital actually receives, "taken together, reflect the amounts the hospital is willing to accept from the vast majority of its patients as payment in full for such services."[5] Such payments are thus highly relevant to determination of reasonable payment amounts.

Third-party payors — commercial health insurers (group or individual), employer-provided health plans, and government programs,

[4] *See North Cypress*, 559 S.W.3d at 132-33; *see also Azar*, 983 F.3d at 530-33 (discussing disparity between hospital chargemaster charges and payments received).

[5] *North Cypress*, 559 S.W.3d at 129.

principally Medicare and Medicaid — cover 90% of patients. They use a wide range of payment methods.[6]

Payment rates by commercial insurance and employer-sponsored (ERISA) plans are set in provider contracts negotiated before services are provided. In Texas, in-network payment rates have not been part of public databases. Health plans and providers have treated them as confidential.

Out-of-network payments have typically been negotiated post-service between the primary health plan and the provider. The health plan sets an amount it will pay. The provider can accept it, or negotiate further with the plan, or bill the patient for the difference between the billed charge and the plan's payment. Balance billing of the patient by the provider for some or all of the billed charge amount that the insurer does not pay is a major concern in such scenarios. Patients, especially when surprised to be billed by out-of-network providers, want to know what in-network payments the providers accept.

Congress and state legislatures have responded by requiring plans to disclose median in-network rates, and by regulating balance or "surprise" billings.

[6] *Azar*, 983 F.3d at 531.

For example, consider Texas S.B. 1264, which in 2019 amended Texas Insurance Code provisions regulating most healthcare services paid for by Texas HMOs, PPOs and EPOs (Exclusive Provider Plans). S.B. 1264 precludes balance billing of the patient and establishes criteria for an arbitrator or mediator to find the reasonable payment.[7] TDI has implemented S.B. 1264 by requiring values for the 80th percentile of charges and the 50th percentile of allowed amounts for a service in the provider's geozip (three-digit zip code) as compiled by FAIR Health.[8] Neither TDI nor FAIR Health require health plans providers to disclose negotiated rates.

I. The new federal laws underscore the need for discovery to determine reasonable payment in a given case.

A. The CMS Price Transparency Rule.

Acting under the Affordable Care Act, CMS adopted a new price transparency rule.[9]

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[7] Available at https://capitol.texas.gov/tlodocs/86R/billtext/pdf/SB01264F.pdf (visited June 8, 2020).

[8] *See* https://www.tdi.texas.gov/medical-billing/idr-process-faqs.html (visited January 28, 2021) (listing 10 factors that must be considered in arbitration, including the FAIR Health database 80th percentile of charges and 50th percentile of payments).

[9] *See generally* https://www.cms.gov/hospital-price-transparency; CMS's Final Rule is available here: https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf (websites visited January 25, 2021).

Cost-control was one goal, because "lack of price transparency has contributed to an 'upward spending trajectory' in healthcare."[10]

Starting January 1, 2021, each hospital must do two things.

- Provide a machine-readable digital file for all items and services not only of its gross charges but also of: its standard discounted cash prices to patients whose care is not covered by any insurance, plan or program; its payor-specific negotiated charges; and its minimum and maximum negotiated charges.[11]
- For each of up to 300 "shoppable services" — common bundles of services, such as colonoscopies, which a patient can schedule in advance — display that information to consumers.[12]

Whether and to what extent consumers and researchers will find the hospitals' data accessible and reliable is an open question, with the answer likely years away.

[10] *Azar*, 983 F.3d at 532.

[11] *See* 45 CFR §180.50.

[12] *See* 45 CFR §180.60.

B. The No Surprises Act.

The No Surprises Act regulates payments to out-of-network providers, both hospitals and professionals. It prohibits balance billing of the patient beyond the co-insurance amount for which the patient is responsible under the plan documents or insurance policy.

Effective January 1, 2022, for emergency and certain other out-of-network services, a health insurer or ERISA plan will pay the provider an initial payment set at the median of the payor's contracted (in-network) rates in the same insurance market for the same or similar items of service, by the same or similar specialty, in the geographic region. (It does not require health plans to disclose rates with individual providers for all services.)

The ultimate payment amount will be determined by negotiation or baseball-style arbitration. The arbitrator must consider the median in-network rates, initially using 2019 contracts adjusted for CPI inflation, and other listed factors. The provider's charges and government program payment amounts are not to be considered.

Both laws emphasize the importance of knowing negotiated rates in resolving payment disputes for medical services, and the CMS rule promotes the transparency of such rates.

II. Discovery of health plan payments to providers is consistent with the new federal laws.

A. Health insurer and ERISA plan payment amounts.

Discovery is necessary to find the rates health plans paid to a provider for specific services. There is no public database in Texas with these rates for all services. The Texas public databases have limitations that may make discovery necessary in a given case, especially of medical damages in a suit such as this one, where no claim was filed with any health plan or government program.

Consider, for example, the Texas Healthcare Costs Consumer Information Guide. A 2007 Texas statute requires the Texas Department of Insurance to, in TDI's words, "collect data from health plans to determine how much they pay doctors and hospitals for specific medical services."[13] These data are of little use in most litigation, for these reasons:

- Individual facilities and practitioners are not identified.
- TDI has only posted data "from claims paid by health plans in 2017."[14]
- TDI only collects data from state-regulated plans, not payments by ERISA (federally regulated employer self-insurance) plans.

[13] https://texashealthcarecosts.org

[14] *Id*.

- TDI does not collect data for all services, and its geozips (3-digit zip codes) do not correspond to medical markets for many services.
- The results are presented in averages. Averages shed little light on what state-regulated plans pay a specific provider. For this reason, most databases report the results by percentiles.

The Texas Health Care Information Collection, administered by the Department of State Health Services, collects data on charges by hospitals, surgery centers, and freestanding emergency departments. The department is prohibited from releasing data on payment amounts.[15]

B. Medicare and Medicaid.

This Court in *North Cypress* recognized the relevance of Medicare rates to determination of an appropriate payment for medical services when the provider bills an uninsured patient its full chargemaster charges.[16]

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[15] Texas Health and Safety Code, Ch. 108; *see* section 108.13(c)(3)-(4) ("…the department may not release and a person or entity may not gain access to any data obtained under this chapter… disclosing provider discounts or differentials between payments and billed charges [or] relating to actual payments to an identified provider made by a payer….").

[16] 559 S.W.3d at 129 (describing Medicare payment discovery) and 134 (requiring disclosure of Medicare payments and Medicare cost reports). In tort suits like this one the parties are different but the issue is similar. The plaintiff may have insurance or be covered under a government program, but the providers may not make claims on such coverage, instead entering into a letter of protection. The provider's charges are, just as in *North Cypress*, subject to challenge for reasonableness because the factfinder must ultimately determine the appropriate payment for medical services as part of damages.

Medicare, Medicaid, and Texas workers' compensation rates are publicly available in governmentally-set fee schedules. But access to those rates is not sufficient to determine reasonable payment rates since providers seldom agree Medicare or Medicaid rates are adequate. Medicare payments are usually relevant but not dispositive, and public Medicare data does not eliminate the need for discovery.

Moreover, discovery from a provider may be needed even as to its Medicare payments, for at least two reasons.

First, while most healthcare economists should be able to determine the Medicare payment for a particular provider for most services if they have certain claims data, often they do not have access to those data.

Medicare publishes a PC Pricer for inpatient claims.[17] The pricer calculates the allowable amount for a specific claim at a specific hospital based on the Medical Severity Diagnostic—Related Group (MS-DRG) to which the admission is assigned, and other data. If the claim does not have the MS-DRG, commercially available software like Microdyn's Encoder Plus can assign it — if the claim contains the necessary data.

The necessary information is sometimes missing from the provider's claim. This happens frequently when services are delivered under a letter

[17] https://www.cms.gov/Mediare/Medicare-Fee-for-Service-Payent/PCPricer/inpatient.

of protection in personal injury cases. Discovery of the missing data is often necessary to calculate the Medicare rate.

Second, if the plaintiff is enrolled in a Medicare or Medicaid managed care plan, the Medicare fee schedule rates may not be the payment the provider actually receives. Medicare and Medicaid managed care organizations negotiate provider contracts just as commercial insurers do. Often the negotiated rates differ from the Medicare fee schedule; sometimes significantly.

Such rates apply to more and more Medicare claims, and most Medicaid claims in Texas. Without discovery of the payments the provider actually receives from Medicare and Medicaid managed care organizations for the same or similar services, the parties and factfinder will not have relevant information to use in determining reasonable payment amounts.

C. Implant costs and charges illustrate the importance of discovery.

St. Camillus charged the injured plaintiff $662,332.92 for cervical spine surgery. *See* Mandamus Record (MR) at 184-93, 449, 633-38. Of this total, St. Camillus charged $528,568 for implants used in the surgery. *See* MR at 185, 624. The record does not show how much of the $528,568 was mark-up versus actual cost. The narrowed discovery requests at issue

here seek that critical information. *See* Relators' Brief on the Merits at 22-23 (Requests 48-64).

Implants used in surgery are typically ordered by the surgeon, delivered to the operating room by the vendor the day of the surgery, and invoiced to the hospital shortly after the surgery. The hospital has no cost for stocking the implant or any other cost beyond the invoice other than entering the invoice in its accounting system.

The invoice cost cannot be determined from any public database. Hospitals often mark up their charges for implants dramatically. In RPC's experience, a 300-400% markup is common.

Regulated payment systems typically do not pay the markup. The Texas workers' compensation fee guideline, for example, pays hospitals "at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." 28 Tex. Admin. Code § 134.404(g). Hospitals must send the payor a copy of the invoice with the claim.[18]

[18] A hospital has the option of being paid 108% of the Medicare DRG payment plus payment for the implants or 143% of the Medicare rate with no additional payment for the implants. *See* 28 Tex. Admin. Code § 134.404(f)-(g).

Medicare does not pay the markup. The providers do not bill Medicare separately for the implants. Each MS-DRG payment amount covers both the services and any implant costs and other out-of-pocket hospital or surgery center expenses.

Because implant charges constitute so much of St. Camillus' total charges, it appears quite likely that its mark-up was even more than the 300-400% markups that are common.

Discovery of invoice costs for implants, the hospital's mark-ups of charges for implants, and how provider contracts pay for implants is necessary to make a reasonable determination of medical damages.

CONCLUSION AND PRAYER

Amicus Curiae Research and Planning Consultants, L.P. prays that the Court receive and consider this Brief, and order the trial court to vacate the disputed orders and grant Relators' narrowed discovery requests.

Respectfully submitted,

GRAVES DOUGHERTY HEARON & MOODY
A Professional Corporation
401 Congress Avenue, Suite 2700
Austin, Texas 78701-3744
(512) 480-5673 (telephone)
(512) 480-5873 (facsimile)

/s/ P.M. Schenkkan
P.M. Schenkkan
State Bar No. 17741500
Matthew B. Baumgartner
State Bar No. 24062605
pschenkkan@gdhm.com
mbaumgartner@gdhm.com

CERTIFICATE OF COMPLIANCE

I certify that, according to my word processor's word-count function, in the sections of the brief covered by Texas Rule of Appellate Procedure 9.4(i)(1), there are 2,433 words.

/s/ P.M. Schenkkan
P.M. Schenkkan

CERTIFICATE OF SERVICE

I certify that, on January 29, 2021, I served a copy of this Amicus Curiae Brief *via* the e-filing portal on:

Counsel for Relators:

Wade C. Crosnoe (wcrosnoe@thompsoncoe.com)
Elizabeth Lee Thompson (lthompsoncoe.com)
William H. Chamblee (wchamblee@cr.law)
Weston L. Hall (whall@cr.law)

Counsel for Real Parties in Interest Kevin Walker & Latunija Johnson:

Rosalyn R. Tippett (rtippett@tippettlawoffice.com)
J. Martin Futrell (martin.futrell@witheritelaw.corn)
Amy K. Witherite (amy.witherite@witheritelaw.com)

Counsel for Real Parties in Interest Saint Camillus Medical Center, Andrew Indresano, M.D., and Pine Creek Medical Center:

Morgan A. McPheeters (morgan@mcpheeterslaw.com)

Court Coordinator for Respondent Hon. Aiesha Redmond:

Nicholas Zaragoza (Nicholas.Zaragoza@dallascounty.org)

/s/P.M.Schenkkan
P.M. Schenkkan

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below:

Jeannette Langer on behalf of Pete Schenkkan
Bar No. 17741500
jlanger@gdhm.com
Envelope ID: 50159676
Status as of 1/29/2021 9:08 AM CST

Associated Case Party: American Property Casualty Insurance Assocation

Name	BarNumber	Email	TimestampSubmitted	Status
Melissa ALorber		mlorber@enochkever.com	1/29/2021 9:01:23 AM	SENT
Laci Lindsey		llindsey@enochkever.com	1/29/2021 9:01:23 AM	SENT
Sara B.Churchin		schurchin@enochkever.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Saint Camillus Medical Center

Name	BarNumber	Email	TimestampSubmitted	Status
Kirk Pittard		kpittard@dpslawgroup.com	1/29/2021 9:01:23 AM	SENT
Christopher M. McDowell	24002571	cmcdowell@mcdowelllawfirm.net	1/29/2021 9:01:23 AM	SENT
Janet Lee McDowell		janetlee@mcdowelllawfirm.net	1/29/2021 9:01:23 AM	SENT
Tammy Holt		tholt@dpslawgroup.com	1/29/2021 9:01:23 AM	SENT
Kelly Blackburn		efile@dpslawgroup.com	1/29/2021 9:01:23 AM	SENT

Case Contacts

Name
Rosalyn RTippett
Wade Crosnoe
Henry Paoli
Weston Hall
Morgan McPheeters
Ruth H.Davis
Elizabeth Lee Thompson
Martin Futrell
William Chamblee
Megan Daly

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Jeannette Langer on behalf of Pete Schenkkan
Bar No. 17741500
jlanger@gdhm.com
Envelope ID: 50159676
Status as of 1/29/2021 9:08 AM CST

Case Contacts

P Schenkkan		pschenkkan@gdhm.com	1/29/2021 9:01:23 AM	SENT
Baumgartner Matthew		mbaumgartner@gdhm.com	1/29/2021 9:01:23 AM	SENT
Jeannette YLanger		jlanger@gdhm.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Kevin Walker

Name	BarNumber	Email	TimestampSubmitted	Status
J. Martin Futrell	24085777	martin.futrell@witheritelaw.com	1/29/2021 9:01:23 AM	SENT
Amy Witherite	788698	amy.witherite@witheritelaw.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Thomas Gothard

Name	BarNumber	Email	TimestampSubmitted	Status
William H. Chamblee	4086100	whchamblee@chambleeryan.com	1/29/2021 9:01:23 AM	SENT
O. Luke Davis	5532700	ldavis@cr.law	1/29/2021 9:01:23 AM	SENT
Wade Caven Crosnoe	783903	wcrosnoe@thompsoncoe.com	1/29/2021 9:01:23 AM	SENT
Elizabeth Lee Thompson	788290	lthompson@thompsoncoe.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Aiesha Redmond

Name	BarNumber	Email	TimestampSubmitted	Status
Aiesha Redmond		Nicholas.Zaragoza@dallascounty.org	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Texas Hospital Association

Name
Cesar Lopez
Steve Wohleb

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Jeannette Langer on behalf of Pete Schenkkan
Bar No. 17741500
jlanger@gdhm.com
Envelope ID: 50159676
Status as of 1/29/2021 9:08 AM CST

Associated Case Party: Texas Hospital Association

Cesar Lopez		clopez@tha.org	1/29/2021 9:01:23 AM	SENT
Steve Wohleb		swohleb@tha.org	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Texas Medical Association

Name	BarNumber	Email	TimestampSubmitted	Status
Donald P.Wilcox		rocky.wilcox@texmed.org	1/29/2021 9:01:23 AM	SENT
Kelly M.Walla		kelly.walla@texmed.org	1/29/2021 9:01:23 AM	SENT
Donald P.Wilcox		rocky.wilcox@texmed.org	1/29/2021 9:01:23 AM	SENT
Laura J.Thetford		laura.thetford@texmed.org	1/29/2021 9:01:23 AM	ERROR
Kelly M.Walla		kelly.walla@texmed.org	1/29/2021 9:01:23 AM	SENT
Laura J.Thetford		laura.thetford@texmed.org	1/29/2021 9:01:23 AM	ERROR

Associated Case Party: Advanced Diagnostics Health System, LLC

Name	BarNumber	Email	TimestampSubmitted	Status
Ellen Peeples	24066797	ellen.peeples@dtlawyers.com	1/29/2021 9:01:23 AM	SENT
Jillian Schumacher		jillian@dtlawyers.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Pine Creek Medical Center

Name	BarNumber	Email	TimestampSubmitted	Status
Morgan A.McPheeters		morgan@mcpheeterslaw.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Texas Civil Justice League, Inc.

Name	BarNumber	Email	TimestampSubmitted	Status
George ScottChristian		george@tcjl.com	1/29/2021 9:01:23 AM	SENT

Automated Certificate of eService

This automated certificate of service was created by the efiling system. The filer served this document via email generated by the efiling system on the date and to the persons listed below:

Jeannette Langer on behalf of Pete Schenkkan
Bar No. 17741500
jlanger@gdhm.com
Envelope ID: 50159676
Status as of 1/29/2021 9:08 AM CST

Associated Case Party: Tri-City Pain Association, P.A.

Name	BarNumber	Email	TimestampSubmitted	Status
Adriaan T.Jansee		aj@jansselaw.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Texas Orthopaedic Association

Name	BarNumber	Email	TimestampSubmitted	Status
Andrea Schwab		andrea@aschwablaw.com	1/29/2021 9:01:23 AM	SENT

Associated Case Party: Texas Trial Lawyers Association

Name	BarNumber	Email	TimestampSubmitted	Status
Jim M.Perdue		jperduejr@perdueandkidd.com	1/29/2021 9:01:23 AM	SENT
Kelly E.Cook		kcook@wylycooklaw.com	1/29/2021 9:01:23 AM	SENT
Matthew J.Kita		matt@mattkita.com	1/29/2021 9:01:23 AM	SENT
John Gsanger		john@ammonslaw.com	1/29/2021 9:01:23 AM	SENT