No. 10-56529

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PALOMAR MEDICAL CENTER,
Plaintiff-Appellant,

v.

KATHLEEN SEBELIUS, Secretary of Health and Human Services,
Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

SUPPLEMENTAL BRIEF FOR THE APPELLEE

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TABLE OF CONTENTS

Page

INTRODUCTION. 1

ARGUMENT. 3

I. Medicare Regulations Bar Administrative Review Of A Contractor's Threshold Decision Whether To Reopen A Claim Determination, Including Whether The Contractor Complied With The Good Cause Standard For Reopening. 3

II. Federal Courts Do Not Have Jurisdiction In The First Instance To Enforce A Contractor's Compliance With The Good Cause Standard For Reopening. 9

CONCLUSION. 15

CERTIFICATE OF COMPLIANCE PURSUANT TO FED. R. APP. P. 32(a)(7)(B)

CERTIFICATE OF SERVICE

TABLE OF AUTHORITIES

Cases:

Anaheim Mem. Hosp. v. Shalala, 130 F.3d 845 (9th Cir. 1997). 7, 10, 14-15

Barrientos v. 1801-1825 Morton LLC, 583 F.3d 1197 (9th Cir. 2009). 8

Califano v. Sanders, 430 U.S. 99 (1977). 10-11

Carpenter v. Mineta, 432 F.3d 1029 (9th Cir. 2005). 6

Connett v. Barnhart, 340 F.3d 871 (9th Cir. 2003). 11

INS v. Ventura, 537 U.S. 12 (2002). 11, 12

Loma Linda Univ. Med. Ctr. v. Leavitt, 492 F.3d 1065 (9th Cir. 2007). 10, 14

Recinos de Leon v. Gonzales, 400 F.3d 1185 (9th Cir. 2005). 11

SEC v. Chenery Corp., 332 U.S. 194 (1947). 11

Schweiker v. McClure, 456 U.S. 188 (1982). 9

Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1 (2000). 9, 13, 14

Thomas Jefferson Univ. v. Shalala, 512 U.S. 504 (1994). 7

United States ex rel. Accardi v. Shaughnessy, 347 U.S. 260 (1954). 10-11

Vista Hill Found., Inc. v. Heckler, 767 F.2d 556 (9th Cir. 1985). 11

Your Home Visiting Nurse Servs., Inc. v. Shalala,
525 U.S. 449 (1999). 6, 7-8, 12

Statutes:

Social Security Act:

42 U.S.C. § 405(g). 9, 11
42 U.S.C. § 405(h). 10

Medicare Act:

42 U.S.C. § 1395h(a).. 9
42 U.S.C. § 1395u(a).. 9
42 U.S.C. § 1395ff(b)(1)(A). 9, 10, 15
42 U.S.C. § 1395ff(b)(1)(G). 3, 5, 8
42 U.S.C. § 1395ii.. 10
42 U.S.C. § 1395kk-1(a)(1). 9
42 U.S.C. § 1395kk-1(a)(4)(A).. 9
42 U.S.C. § 1395kk-1(a)(4)(G).. 9

28 U.S.C. § 1331. 10
28 U.S.C. § 1346. 10

Regulations:

42 C.F.R. § 405.926(1). 1, 2, 4, 5-6, 7
42 C.F.R. § 405.980(a)(1). 3
42 C.F.R. § 405.980(a)(5). 1, 2, 4, 6, 7
42 C.F.R. § 405.980(b)(1). 4
42 C.F.R. § 405.980(b)(2). 1, 2, 4, 6
42 C.F.R. § 405.980(b)-(e). 3
42 C.F.R. § 405.984.. 4
42 C.F.R. § 405.986.. . . . . 1, 2, 4, 6, 7
42 C.F.R. § 405.986(a). 4, 12

42 C.F.R. § 405.986(b). 12
42 C.F.R. § 405.986(c). 12
42 C.F.R. § 405.1130 (2008).. 10

70 Fed. Reg. 11,420 (Mar. 8, 2005). 3, 4, 5, 7
74 Fed. Reg. 65,296 (Dec. 9, 2009). 5

INTRODUCTION

In 2007, pursuant to an audit under the Congressionally established Recovery Audit Contractor program, a Medicare contractor reopened a claim for reimbursement submitted in 2005 by appellant Palomar Medical Center ("Palomar"). The contractor determined that Palomar was overpaid almost $8000 on the claim. Palomar unsuccessfully contested the overpayment determination through four levels of administrative review, but no longer challenges that determination.

However, Palomar also asserted that the reopening was untimely because it occurred two years after the initial claim determination, allegedly without good cause. Palomar relied upon a Medicare regulation that authorizes contractors to reopen initial determinations within one to four years from the date of the initial determination or redetermination for "good cause" as defined in another regulation. See 42 C.F.R. §§ 405.980(b)(2), 405.986. An administrative law judge ("ALJ") agreed with Palomar, but the Medicare Appeals Council ("MAC") – the final decisionmaker for the Department of Health and Human Services ("HHS" or "the agency") – overturned that ruling, relying on other regulations stating that "[a] contractor's * * * decision to reopen or not to reopen an initial determination" is "not appealable." *Id*. § 405.926(l); see also *id*. § 405.980(a)(5) (contractor's decision whether to reopen is "not subject to appeal"). The MAC noted that, in the rulemaking that produced those regulations and the ones on which Palomar relies, HHS explained

that it would instead enforce contractors' compliance with the timeliness and good cause requirements through audits and evaluations of contractor performance.

Palomar sought judicial review of the MAC's final decision. Like the three other courts that have ruled on the same issue, see HHS Br. 32, the district court upheld the MAC's decision, and Palomar appealed. After oral argument, the Court invited additional *amicus* briefs addressing the following questions:

> (1) Do the regulations at 42 C.F.R. §§ 405.926(*l*) and 405.980(a)(5) bar administrative review of a contractor's decision to reopen a Medicare claim, including the contractor's compliance with the good cause standard for reopening set forth at 42 C.F.R. §§ 405.980(b)(2) and 405.986?
>
> (2) If the regulations bar administrative review of a contractor's decision to reopen, do federal courts have jurisdiction to enforce the agency's compliance with the good cause standard for reopening?

The American Medical Association ("AMA"), joined by nine state medical associations, and the California Hospital Association ("CHA") – both of which previously filed *amicus* briefs in this appeal – filed additional briefs in response to the Court's invitation and in support of Palomar. The Court granted HHS leave to respond to the new briefs of those *amici*.

ARGUMENT

I. Medicare Regulations Bar Administrative Review Of A Contractor's Threshold Decision Whether To Reopen A Claim Determination, Including Whether The Contractor Complied With The Good Cause Standard For Reopening.

A. In 2000, Congress added a provision to the Medicare Act addressed to the "[r]eopening and revision of determinations." 42 U.S.C. § 1395ff(b)(1)(G). It states that HHS "*may* reopen or revise any initial determination or reconsidered determination * * * *under guidelines established by [HHS] in regulations*." *Ibid*. (emphases added). That provision codified HHS's longstanding discretion concerning reopenings. Pursuant to that authority, HHS conducted a notice-and-comment rulemaking and adopted regulations in 2005 permitting the reopening of claims determinations. HHS explained that, "a reopening is a remedial action," the goal of which is "to pay claims appropriately." 70 Fed. Reg. 11,420, 11,450, 11,451 (Mar. 8, 2005). The regulations authorize a Medicare contractor, qualified independent contractor ("QIC"), ALJ, or the MAC to reopen a determination or decision, either *sua sponte* or upon the provider's request, in accordance with specified time frames and criteria. See 42 C.F.R. § 405.980(a)(1), (b)-(e).[1]

[1] Unless otherwise noted, citations are to the 2007 edition of the C.F.R., which contains the regulations in effect at the time of the reopening at issue.

As pertinent here, a contractor "may" reopen an initial determination on its own motion within one year for any reason, or within four years "for good cause as defined in § 405.986." *Id*. § 405.980(b)(1), (2). Good cause may be established when there is "new and material evidence" that was not "available or known at the time of the determination or decision" and that "[m]ay result in a different conclusion," or when the evidence considered in making the determination "clearly shows on its face that an obvious error was made at the time of the determination or decision." *Id*. § 405.986(a).

A revised determination that results from reopening – e.g., that a provider was overpaid – may be appealed through the full administrative review process. *Id*. § 405.984. However, because the decision whether to reopen is a "discretionary action[]" by the contractor, that threshold decision "is not subject to appeal." 70 Fed. Reg. at 11,451. Accordingly, in two separate provisions, the regulations state unequivocally: "Actions that are not initial determinations and are not appealable under this subpart include * * * [a] contractor's, QIC's, ALJ's, or MAC's determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision." 42 C.F.R. § 405.926(l). See also *id*. § 405.980(a)(5) ("The * * * decision on whether to reopen is final and not subject to appeal."). Thus, neither a provider nor the Centers for Medicare and Medicaid Services may challenge a contractor's decision to reopen.

During the rulemaking, comments raised the very questions here at issue, concerning appeals from the decision whether to reopen and enforcement of the good cause standard when a contractor reopens a determination. HHS responded that its "longstanding rule" is that the "failure to grant a request for reopening is not reviewable." 70 Fed. Reg. at 11,453. As for contractor compliance with the regulations, HHS explained that "[t]he regulations require that contractors abide by the good cause standard for reopening actions after one year," and that the agency "assesses a contractor's compliance with Federal laws, regulations and manual instructions during audits and evaluations of the contractors' performance. Thus, the necessary monitoring and enforcement mechanisms are already in place." *Ibid*. HHS reiterated that position in a subsequent rulemaking. 74 Fed. Reg. 65,296, 65,312 (Dec. 9, 2009).

B. *Amici* have wholly ignored HHS's explanation concerning how it enforces contractor compliance with the good cause standard for reopening, as well as the MAC's discussion of that point in the final decision before the Court for review. See ER 69. *Amici* thus err in contending that there is no enforcement of the good cause standard for reopening, that contractors have uncabined discretion, and that the MAC's decision fails to conform to HHS's reopening regulations, as 42 U.S.C. § 1395ff(b)(1)(G) requires. HHS enforces the good cause standard through contractor audits and evaluations, and, contrary to CHA's argument (Br. 11), the MAC decision is fully consistent with *all* of the pertinent HHS regulations, 42 C.F.R.

§§ 405.926(l), 405.980(a)(5), 405.980(b)(2), and 405.986. See *Carpenter v. Mineta*, 432 F.3d 1029, 1034 (9th Cir. 2005) (related regulations should be considered as a whole).[2]

Amici recognize, as they must, that the "no appeal" language in Sections 405.926(l) and 405.980(a)(5) serves some purpose. However, they argue that those regulations foreclose appeal of only the contractor's actual decision to reopen, but that the timeliness and reasons for reopening *are* subject to appeal. Not only is that a strained reading of the regulations' plain language, it is illogical to sever a reopening decision from the basis of that decision. Indeed, CHA concedes (Br. 2) that "whether a claim should be reopened is discretionary and insulated from appeal." See *Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 457 (1999) (reopening is not required and is discretionary). "[W]hether a claim should be reopened" is a simply another way of asking whether there is "[g]ood cause for reopening." 42 C.F.R. § 405.986 (title).

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[2] The AMA is also incorrect in arguing (Br. 4) that there is no opportunity for HHS to correct reopenings based on prohibited grounds. There is nothing to prevent a provider from notifying HHS of a contractor's repeated or flagrant noncompliance with the reopening requirements, outside the context of an individual claim adjudication. HHS, however, is aware of no such problems. (There are also no other court appeals in which a provider seeks to challenge a reopening because of a contractor's alleged noncompliance with the good cause standard. See HHS Br. 32 & n.18.) Moreover, adjudicators can and do bring to the agency's attention problems with individual claims and identify patterns of problems so that HHS can address them directly with the contractors.

In any event, *amici's* interpretation of the "no appeal" regulations is clearly at odds with HHS's intent and the regulations' purpose. HHS's explanation during the rulemaking concerning how it would enforce the good cause standard, see 70 Fed. Reg. at 11,453, eliminates any doubt that Sections 405.926(l) and 405.980(a)(5) preclude appeal of a contractor's threshold decision whether to reopen, and that, as the MAC concluded, "[t]his restriction extends to whether or not the contractor met the good cause standards for reopening." ER 69. Moreover, even if the regulations could be considered ambiguous or in "conflict," as the ALJ here found, ER 88, HHS's interpretation of its own regulations is entitled to "substantial deference * * * unless it is plainly erroneous or inconsistent with the regulation." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (internal quotation marks omitted). See *Anaheim Mem. Hosp. v. Shalala*, 130 F.3d 845, 850 (9th Cir. 1997). HHS's interpretation is fully consistent with both the regulations and the preamble accompanying their adoption.

Amici also mistakenly criticize HHS's reliance on *Your Home*. In that case, the Supreme Court upheld HHS's position, based on its regulations and Medicare manual, that the Provider Reimbursement Review Board ("PRRB") had no jurisdiction to review a fiscal intermediary's refusal to reopen a reimbursement determination. 525 U.S. at 453. To be sure, *Your Home* involved a provider's attempt to obtain reopening, whereas this case involves a provider's objection to a contractor's

reopening decision. However, the Court emphasized the need for the provider "to establish that the [PRRB's] appellate jurisdiction [to review the reopening determination] is somewhere *conferred*," *ibid*., and that applies here as well. Not only has Palomar failed to establish that HHS's regulations confer jurisdiction on any administrative adjudicator to review the contractor's reopening decision, the regulations affirmatively foreclose such review.

The Supreme Court in *Your Home* further recognized that reopening "exists only by grace of [HHS]." *Id*. at 454. See 42 U.S.C. § 1395ff(b)(1)(G) (authorizing, but not requiring, reopening procedure). If HHS could decline to provide for *any* reopening, it follows that it could take an intermediate course, by establishing procedures that permit reopening, but that limit the types of challenges that can be raised in that process.

The AMA's suggestion that HHS has "irrevocably delegate[d] a legal question to a non-governmental body," without "'affirmative evidence' of statutory authority to delegate," Br. 5, fails for multiple reasons. First, Palomar has not raised that argument, and the Court does not consider issues raised on appeal solely by an *amicus*. *Barrientos v. 1801-1825 Morton LLC*, 583 F.3d 1197, 1215 n.8 (9th Cir. 2009). Second, there is no irrevocable delegation of authority to a private entity, because, as discussed above, HHS enforces contractor compliance with its regulations. Third, Congress has explicitly authorized HHS to enter into contracts

with nongovernmental entities to administer the Medicare program, and those contractors may determine payment amounts and perform other functions related to program integrity "as are necessary to carry out the purposes of the [Medicare Act]." 42 U.S.C. § 1395kk-1(a)(1), (4)(A), (G); see also *id*. §§ 1395h(a), 1395u(a). See also *Schweiker v. McClure*, 456 U.S. 188 (1982) (upholding constitutionality of use of private insurance carriers for hearings on disputed Medicare claims).

In sum, like Palomar, *amici* have failed to show that the district court erred in upholding the MAC's decision.[3] As the court concluded, the "plain language" of HHS's regulations "clearly and explicitly bar[s] review of the reopening decisions through [administrative] appeal." ER 8, 9.

II. Federal Courts Do Not Have Jurisdiction In The First Instance To Enforce A Contractor's Compliance With The Good Cause Standard For Reopening.

A. It is well established that the only path to judicial review of a decision on a claim arising under the Medicare Act is that prescribed by Congress in the statute. *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 10 (2000). A party may seek "judicial review of [HHS's] *final* decision" after a hearing "as is provided in [42 U.S.C. § 405(g)]." 42 U.S.C. § 1395ff(b)(1)(A) (emphasis added).

[3] HHS's principal brief (at 43-48) addresses *amici's* argument that HHS has interpreted similar language in other regulations and documents so as to allow appeals from the threshold decision whether to reopen.

Another provision of the Act makes Section 405(h) of Title 42 applicable to Medicare cases. *Id*. § 1395ii. Section 405(h), in turn, provides:

> No * * * decision of [HHS] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, [HHS], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under [the Medicare Act].

Id. § 405(h).

Palomar concedes (Br. 1) that Section 1395ff(b)(1)(A) provides the proper route to judicial review of its claim determination, and it does not dispute that the MAC's decision is the final HHS decision reviewable in court. See 42 C.F.R. § 405.1130 (2008); ER 63-64. In its final decision, the MAC properly followed HHS's regulations and declined to address whether the contractor satisfied the good cause standard for reopening. ER 69.

This Court has repeatedly held that federal district courts have jurisdiction over Medicare disputes only to the extent authorized by Congress, and, when HHS's final decision does not address a given issue, a district court lacks jurisdiction to review that issue. See, e.g., *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065, 1074 (9th Cir. 2007); *Anaheim*, 130 F.3d at 853.[4] See also *Califano v. Sanders*, 430 U.S. 99,

[4] CHA's reliance on the "*Accardi* doctrine" to support its jurisdictional arguments (Br. 11) is misplaced. *United States ex rel. Accardi v. Shaughnessy*, 347 (continued...)

108 (1977) (Section 405(g) limits judicial review to final HHS decision made after hearing, and petition to reopen prior final decision may be denied without hearing). This Court's holdings are rooted not only in the statutory scheme that Congress prescribed for judicial review of decisions arising under the Medicare Act, but also in fundamental principles of administrative law. The Supreme Court long ago explained that a court reviewing "a determination or judgment which an administrative agency alone is authorized to make[] must judge the propriety of such action solely by the grounds invoked by the agency." *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947). This Circuit has applied that rule in various contexts, including Medicare cases. See, e.g., *Recinos de Leon v. Gonzales*, 400 F.3d 1185, 1189 (9th Cir. 2005); *Connett v. Barnhart*, 340 F.3d 871, 874 (9th Cir. 2003); *Vista Hill Found., Inc. v. Heckler*, 767 F.2d 556, 559 (9th Cir. 1985).

Moreover, if the grounds on which the agency's final decision is based "are inadequate or improper, the court is powerless to affirm the administrative action by substituting what it considers to be a more adequate or proper basis." *Chenery*, 332 U.S. at 196. See also *INS v. Ventura*, 537 U.S. 12, 16 (2002) ("A court of appeals 'is not generally empowered to conduct a *de novo* inquiry into the matter being reviewed and to reach its own conclusions based on such an inquiry.'"). Instead, the proper

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[4](...continued)
U.S. 260 (1954), does not address jurisdictional issues.

remedy is to remand the matter to the agency for its determination of the issue in the first instance. *Id*. at 16-17.

Thus, because the MAC did not rule on whether the contractor had good cause to reopen the claim at issue, under the principles discussed above, neither the district court nor this Court has jurisdiction to address that issue in the first instance. Although we urge the Court to affirm the district court's judgment in its entirety, if the Court nevertheless concludes that the MAC should have considered and ruled on the contractor's good cause for reopening, it should remand the case to the district court with instructions to remand to the MAC for a ruling on that issue.

The circumstances of this case demonstrate the wisdom of that approach. As the Supreme Court recognized in *Your Home*, 525 U.S. at 457, reopening is permitted, but not required, and determining whether there is good cause to reopen is itself a "discretionary" decision. Here, although the ALJ found that the RAC contractor did not have good cause for reopening Palomar's claim, ER 90-91, the Qualified Independent Contractor reached the opposite conclusion, ER 238. Thus, given that difference of opinion between subordinate adjudicators and the discretionary nature of the good cause determination, it is unclear how the MAC – the only decisionmaker (other than the Secretary herself) authorized to render a final decision subject to judicial review – would ultimately rule on that issue. Moreover, a court is not well-positioned to make that determination in the first instance.

B. *Amici* do not offer any arguments that undermine the applicability of those basic principles of judicial review, particularly here in the Medicare context. Moreover, their arguments concerning "presentment" and exhaustion of remedies are inapposite; those requirements are not here at issue. *Amici* also misunderstand HHS's "final decision" argument. HHS does not contend that there was *no* final decision for the district court to review. Rather, there is a final decision, but it does not address whether the contractor had good cause to reopen the claim, because Medicare regulations bar consideration of that threshold issue. Thus, there is no final decision *on that issue* for the Court to review. As explained above, if the Court concludes that the agency should have addressed that issue, then it must remand so that HHS can do so in the first instance.

Amici's reliance on *Illinois Council* is unavailing. There, the Supreme Court stated that "[t]he fact that [HHS] might not provide a hearing for [a] *particular contention*, or may lack the power to provide one * * * is beside the point because it is the 'action' arising under the Medicare Act that must be channeled through the agency." 529 U.S. at 23. Moreover, "[a]fter the action has been so channeled, the court will consider the contention when it later reviews the action," and the reviewing court "has adequate authority to resolve any *statutory or constitutional* contention that the agency does not, or cannot, decide." *Ibid*. (emphasis added). However, the Court did not address the circumstance here, which requires the resolution of an issue

based on HHS *regulations*. Nothing in *Illinois Council* implies that the Supreme Court has retreated from its well established principles of deferring to an agency's interpretation of its own regulations and remanding so that an agency can address an issue in the first instance.

Amici's attempts to distinguish *Loma Linda* also fail. In that case, the provider belatedly sought to add an interest expense issue to its pending appeal before the PRRB. Like the ALJ here, the PRRB accepted jurisdiction and concluded, on the merits, that the interest expense had been understated. 492 F.3d at 1069. In "the agency's final decision," the Health Care Financing Administrator reversed, ruling that the PRRB had no jurisdiction over that issue. *Id*. at 1070. The district court refused to reach the merits of the interest expense issue because it had jurisdiction to review only "the final agency decision, i.e., the Administrator's dismissal of the administrative appeal for lack of jurisdiction." *Ibid*. On appeal, this Court agreed, stating that "there is no final agency decision on the merits for purposes of federal court jurisdiction to award reimbursement for interest expense or statutory interest." *Id*. at 1074, 1075. That holding was not affected by the fact that "Loma Linda exhausted its administrative remedies before seeking judicial review." *Id*. at 1071 n.12. The circumstances of this case are virtually indistinguishable.

Anaheim likewise supports HHS's jurisdictional arguments. There the Court emphasized that "[f]ederal courts have jurisdiction over Medicare reimbursement

disputes only to the extent provided by [statute]." 130 F.3d at 853. Moreover, because the final agency decision had not addressed a particular issue, the Court remanded the case to HHS for a final decision on the merits of that issue, *ibid*. – the remedy that would be appropriate here, if the Court concludes that HHS should have addressed whether the contractor had good cause to reopen Palomar's claim. The AMA is simply incorrect in arguing that a remand would serve no purpose because "[t]here is nothing more the Secretary can do," and that, if Palomar's argument is not addressed now, it "will receive no review, ever." AMA Br. 15. Any final decision on good cause issued by HHS on remand would be subject to judicial review under 42 U.S.C. § 1395ff(b)(1)(A).

CONCLUSION

For the foregoing reasons and those in HHS's principal brief, the district court's judgment should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE PURSUANT TO FED. R. APP. P. 32(a)(7)(B)

The Court did not establish a word or page limit for this Supplemental Brief. I certify that this Supplemental Brief complies with Fed. R. App. P. 32(a)(7)(B), because it was prepared using WordPerfect X5, Times New Roman 14-point proportional font, and contains 3,528 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

June 8, 2012

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