In the
Supreme Court of Ohio

CAPITAL CARE NETWORK OF TOLEDO,	:	Case No. 2016-1348
	:	
	:	On Appeal from the
Appellee,	:	Lucas County
	:	Court of Appeals,
v.	:	Sixth Appellate District
	:	
STATE OF OHIO DEPARTMENT OF HEALTH,	:	Court of Appeals Case No. CL-201501186
	:	
Appellant.	:	

REPLY BRIEF OF APPELLANT
STATE OF OHIO DEPARTMENT OF HEALTH

ALPHONSE A. GERHARDSTEIN (0032053)
JENNIFER L. BRANCH* (0038893)
**Counsel of Record*
Gerhardstein & Branch Co., L.P.A.
441 Vine Street, Suite 3400
Cincinnati, Ohio 45202
513-621-9100
513-345-5543 fax
jbranch@gbfirm.com

TERRY J. LODGE (0029271)
316 N. Michigan Street, Suite 520
Toledo, Ohio 43604-5627
419-255-7552
419-255-7552 fax
tjlodge50@yahoo.com

Counsel for Appellee,
Capital Care Network of Toledo

MICHAEL DEWINE (0009181)
Attorney General of Ohio
ERIC E. MURPHY* (0083284)
State Solicitor
**Counsel of Record*
STEPHEN P. CARNEY (0063460)
PETER T. REED (0089948)
Deputy Solicitors
RYAN L. RICHARDSON (0090382)
TIFFANY L. CARWILE (0082522)
Assistant Attorneys General
30 East Broad Street, 17th Floor
Columbus, Ohio 43215
614-466-8980
614-466-5087 fax
Eric.Murphy@OhioAttorneyGeneral.gov

Counsel for Appellant,
State of Ohio Department of Health

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INTRODUCTION

The Department of Health's opening brief showed that this case should be a straightforward administrative appeal about a surgical clinic's noncompliance with a patient-safety regulation, and that the case was transformed procedurally and substantively because that clinic performs abortions. The courts below *failed* to resolve the ultimate issue: whether the clinic violated an administrative rule requiring an outpatient surgical clinic to have a "written transfer agreement" with a local hospital to provide for continuity of care if a patient needs to be rushed to the hospital. Ohio Admin. Code ("O.A.C.") 3701-83-19(E) ("Transfer Agreement Rule" or "Rule"). But both courts raised and decided an "undue burden" argument that the *clinic* rightly said that it "never argued" and "presented no evidence" on. As the Department explained, under the correct rules, a court must uphold the Department's "Adjudication Order" revoking the license of Capital Care Network of Toledo (the "Clinic").

In response, the Clinic now endorses and defends the lower courts' mistakes about the scope of the case, retracting or ignoring its previous concessions and insisting—even against its own prior statements—that the Transfer Agreement Rule was never at issue, and urging this Court to reach the un-raised undue-burden issue. That is, the parties once agreed on the case's scope and disagreed only on the outcome of issues such as the one-subject rule claim and the due-process "delegation" claim. But now, the parties dispute the case's procedural scope as well as its substantive outcome. The Department urges the Court simply to follow the normal procedural rules that determine when issues are preserved or waived, and to review the papers below to resolve the parties' disputes about what issues are live. If it does so, the Court should reject the Clinic's challenges to the Department's Order by resolving all issues as follows.

First, the Court should uphold the Department's Order based on the Transfer Agreement Rule alone: The Rule was an independent basis for the Order, and the Clinic did not satisfy its

requirements. That allows the Court to avoid all unnecessary constitutional issues regarding the parallel "Transfer Agreement Statute," R.C. 3702.303(A). The Clinic mistakenly insists that the Department did not rely on the Rule. But the Clinic ignores the Order's text, as well as the Clinic's own acknowledgements that the Rule was at issue, including its arguments about the Rule at the hearing and its citation of the Rule in its notice of appeal. And the Clinic does not satisfy the Rule, as its arrangement with an Ann Arbor hospital is not adequate for emergencies.

Second, the Court should reject the one-subject challenge to the Transfer Agreement Statute, if it reaches the issue. The Clinic attacks the statute as not linked to spending, but a budget bill is about state *operations*, and a provision meets the one-subject rule if connected to another that relates to operations or spending. *See State ex rel. Ohio Civ. Serv. Emps. Assn. v. State*, 146 Ohio St. 3d 315, 2016-Ohio-478, ¶¶ 30, 33-34 ("*OCSEA*"). Here, two provisions—the "Variance Statute" (R.C. 3702.304) and "Public Hospital Statute" (R.C. 3727.60)—involve state operations and link the Transfer Agreement Statute to the budget bill.

Third, the Court should set aside the "undue burden" issue, for, as the Clinic rightly admits, it never raised the issue and presented *no factual evidence* to support what should be a fact-intensive inquiry. The Clinic now embraces this court-raised issue, but its attempted justifications fail, as neither the law nor facts were developed below. Nor is remand justified to allow such development, as such a claim can be raised, and indeed has been, in another case.

Fourth, the Court should reject (if reached) the "delegation" attack on the Transfer Agreement Statute, just as the Sixth Circuit rejected an identical attack on the Rule. *Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595 (6th Cir. 2006). Adopting that mistaken view would eliminate transfer-agreement laws for all surgical clinics, and would threaten many other laws.

In sum, the Order should be upheld under the Rule, and all else should be set aside.

ARGUMENT

While this case might seem to raise several issues, most are irrelevant to the ultimate issue—whether the Adjudication Order revoking the Clinic's license was supported by reliable, probative, and substantial evidence and is in accordance with the law. Because that Order was based independently upon the Transfer Agreement Statute and the Transfer Agreement Rule, the Court should uphold the Order under the Rule and avoid the constitutional attacks on the statute.

As detailed below, the Clinic's insistence that the Rule is not at issue fails, as it cannot refute—and does not even acknowledge—its own earlier, repeated admissions that the Rule was at issue. The Clinic's constitutional claims—on one-subject, undue burden, and delegation—need not be reached, and if they are, all fail on the merits. The undue-burden claim especially should not be reached, as it was not preserved legally or supported factually at any level.

The Court should treat this as an ordinary administrative case. The Clinic should lose its license for failing to meet a health-and-safety law, and its constitutional claims do not matter.

A. The Clinic's failure to meet the Rule has always been at issue, as the Clinic once admitted, and that resolves the case.

The Court should "not reach constitutional issues unless absolutely necessary." *State v. Talty*, 103 Ohio St. 3d 177, 2004-Ohio-4888 ¶ 9. As the Department's opening brief explained, that means resolving *this* case based solely on the Clinic's noncompliance with the 1996 Transfer Agreement Rule. In response, the Clinic largely insists that the Rule has never been at issue, and it also says it satisfied the Rule anyway. It is wrong on both scores.

1. The Rule has always been at issue, and the documentary record shows that the Clinic treated the Rule as such until dropping it.

The Department detailed how the Adjudication Order relied on the Rule as well as the Statute, citing not only the Order, but al so the Clinic's own statements at the hearing and in its notice of appeal. ODH Br. 24-25. Despite that, the Clinic insists that the Rule was never at

issue, and that the Department invokes it improperly. Clinic Br. 14-15. The Clinic is simply mistaken, as the record shows. At every step of the process, the Rule was in play, and the Clinic even said so, too.

The notices. Both notices of proposed violations cited the Rule, ODH Br. 10, 24-25, and the Clinic's contrary denial is wrong. The Clinic says that the second notice, in February 2014, relies only on the Statute, and it cites a line in the notice quoting the Statute. Clinic Br. 10 (citing Second Notice, ODH Hearing Ex. H, Supp. at S-104-06). While that sentence (at S-105) cites the Statute alone, the rest of the Notice, including the opening line (at S-104), cites twin "violations of R.C. 3702.303 and Ohio Admin. Code 3701-83-19(E)."

The hearing. The hearing confirmed that the Rule was at issue. The parties agreed that both notices were at issue, Tr. 9, Supp. at S-7, with the First Notice citing just the Rule and issued when the Clinic had *no agreement* of any type, and the Second Notice, citing both Rule and Statute, and issued after the Clinic signed the "Ann Arbor Arrangement." Notably, the Clinic's counsel explained at the hearing her understanding that the Rule applied to the Ann Arbor Arrangement even if the Statute were invalidated, and she said the Clinic met the Rule:

> If House Bill 59 and Ohio Revised Code 3702.303 are held to be unconstitutional, then we're left with the administrative code, which says that a written transfer agreement must be with a hospital. It doesn't use the word "local." And our argument would be Capital Care has a transfer agreement under the regs, therefore they meet the licensure requirement and their license should not be revoked; and, in fact, it should be renewed.

Tr. 14-15; Supp. at S-8-9. That statement leaves no doubt that the Rule was at issue *both* as to the period in which the Clinic had no agreement (and thus was admittedly out of compliance) and as to the period with the Ann Arbor Arrangement, i.e., whether it met the Rule.

Consistent with that understanding, Dr. Wymyslo, the Department's former director, testified that any agreement that did not satisfy the Statute's "local" hospital requirement would

also fail to meet the Rule. That was so because the Rule required an agreement that would be effective in emergencies, and, in his view, a hospital should be reachable within 30 minutes to be effective for emergencies *or* to be considered local. Tr. 124-25, Supp. at S-36. The Hearing Examiner asked whether Dr. Wymyslo had "use[d] that standard prior to when the statute was enacted," and Dr. Wymyslo confirmed that it was an "expectation that is reasonable any time, correct, whether they use . . . the term local or not." *Id.* So the Clinic's failure to meet the Statute's "local" requirement also meant that it failed to meet the Rule, according to testimony *at the hearing*. Likewise, the Clinic presented evidence that it believed showed the effectiveness of its arrangement, which went to the Rule's requirement as well as the Statute's.

Against all this, the Clinic insists that the Rule was never at issue in the agency process, and it accuses the Department of raising the Rule "for the first time on appeal." Clinic Br. 14. The Clinic says that any "reference to the regulation" in the administrative process "does not apply to the Michigan agreement." *Id.* And it complains that it would violate due process to affirm the Order now based on the Rule, because, it says, it never had notice and a hearing for an opportunity to show how it satisfied the Rule. *Id.* at 15.

The Clinic's current revisionism conflicts sharply with all of the above, including the Clinic's opening statement at the hearing that its "argument would be Capital Care has a transfer agreement under the regs." It is hard to see why the Clinic would argue that the agreement satisfies the Rule ("the regs") if it had no idea that the Rule was at issue. Although the Department cited this statement in its brief, ODH Br. 25, the Clinic failed to respond to it. And the Clinic cannot explain what evidence it would purportedly present that it did not already.

The Adjudication Order. The Order revoked the Clinic's license "in accordance with R.C 3702.303, R.C 3702.303(A), R.C. Chapter 119 and *O.A.C. 3701-83-19(E).*" Order 1 (emphasis

added). The Clinic insists that the Department "did not rely on the Rule in the revocation Order," Clinic Br. 11, but it fails to acknowledge, let alone explain away, the citation to the Rule—again, despite the Department's stress on that cite in its brief, ODH Br. 4, 12, 25.

The Clinic's notice of appeal. Any doubt about the hearing's scope is confirmed by the Clinic's own notice of appeal, filed to appeal the Order from the agency to the common pleas court. That notice asserts that the Clinic "has complied with the law of Ohio including R.C. 3702.30 and the Ohio Administrative Code, including O.A.C. 3701-83." Notice of Appeal, Supp. at S-119-20. The Clinic cannot explain why its notice would assert compliance with the Ohio Administrative Code if only the Statute, not the Rule, were at issue.

The common pleas court. Because the Order was based on the Rule as well as the Statute, it was the *Clinic's* job, as the *appellant* in the common pleas court, to overcome both bases and thus show that the Order was not in accordance with law. But the Clinic, after identifying the administrative code in its notice of appeal, failed to address the Rule in its appellant's brief. It did not claim to satisfy the Rule, or challenge its validity.

In response, the Department opened its brief with a plain statement that it "properly revoked and refused to renew the license of [the Clinic] because [the Clinic] failed to obtain a written transfer agreement with a local hospital as R.C. 3702.03(A) and *Ohio Adm. Code 3701-83-19(E)* require." Department's Common Pleas Br. 1 (emphasis added).

The Clinic gets it exactly backwards in now saying that the *Department* waived the Rule's relevance by not saying more in the common pleas court. Clinic Br. 15. (And the Department did not "admit" that it "did not articulate" the Rule as a basis in common pleas court, *id.*, as the Department has consistently explained, ODH Br. 25, that its opening line in its brief in that court was more than enough *as appellee* after the Clinic said nothing.) The case the Clinic

cites involved the duty of a *claimant-appellant*, who had a burden to meet, to preserve an argument. *See State ex rel. Zollner v. Indus. Comm.*, 66 Ohio St. 3d 276, 277 (1993) (claimant who failed to raise argument below waived it). As appellee, the Department not only had no burden, but could have skipped filing a brief altogether, and the Clinic still would have needed to meet its burden by showing that the Order was not legally supported. The *Clinic* needed to show that it satisfied the Rule, as it promised in its notice of appeal. But it did not do so.

The appeals court. The appeals court repeatedly cited the Rule as part of the case. *Capital Care Network of Toledo v. State of Ohio Dep't of Health*, 2016-Ohio-5168 (6th Dist.), App'x 2 ¶¶ 5, 7, 9, 12. But it analyzed only the Statute, concluding without returning to the Rule. The court was wrong not to address the Rule, but it was right to describe it as a live issue.

In sum, the record shows that the Rule has always been part of this case, so the Court can and should resolve this case on the basis of the Rule alone.

2. The Clinic did not satisfy the Rule, so the Order was properly based on that non-compliance, and no remand is justified for the Clinic to try again.

Once the Court confirms that the Rule is at issue, the case is easily resolved: The Department correctly found that the Clinic's Ann Arbor Arrangement does not satisfy the Rule. ODH Br. 17-23. Thus, the Order, in revoking the Clinic's license based on its failure to have a transfer agreement that complied with *either* the Statute *or* the Rule, was supported by reliable, probative, and substantial evidence and was in accordance with the law. R.C. 119.12. The Clinic argues now, as it did at the hearing, that it meets the Rule, Clinic Br. 13, but it is wrong.

The Clinic's brief attempt to show that it meets the Rule fails on its own terms, and it also fails to grapple with the key point that Ann Arbor is too far away to be part of an effective plan for "emergency situations," as the Rule requires. Dr. Wymyslo testified why he thought a hospital should be within 30 minutes, and how his medical experience led him to use that

standard under the Rule (before the Statute was enacted). ODH Br. 19-23; Tr. 124-25, Supp. at S-36; *id*. at 58-59, Supp. at S-19-20. The Clinic does not refute that, and it does not try to show that 42 miles is good enough. Instead, it says other things that miss the mark.

First, the Clinic mistakenly says that the Ann Arbor Arrangement "satisfied the rule by explicitly stating that the hospital agrees to admit patients, including those with emergency medical conditions," as if location were irrelevant. Clinic Br. 13. The Clinic says that "the only reason the Director rejected the [Ann Arbor Arrangement] was because of the location of the hospital in Ann Arbor, MI." *Id.* That wrongly suggests that location plays *no role*, even under the Rule, so a California hospital would be enough. Location matters, and the Clinic's insistence that it does not matter at all, and its failure to even try to justify the distance here, is dispositive.

Second, the Clinic tries again to rely on its helicopter plan, Clinic Br. 13, but the Department rightly found that such a speculative "plan" was not solidified. ODH Br. 22-23. Dr. Wymyslo testified that he was not aware of the plan earlier (as the Clinic raised it at the hearing), but he thought such a transfer was neither safe nor immediate. Tr. 73, Supp. at S-23.

Third, the Clinic is wrong in questioning the need for any transfer agreement at all, saying that it would just call 911 in an emergency. Clinic Br. 13. That argument does not show that its purported plan *meets* the Rule, but says that no agreement should be needed to begin with, because 911 is good enough. But the Clinic has not challenged the Rule's validity, and Ohio's Rule has been upheld. *Baird*, 438 F.3d at 607, 609. The federal government and medical associations have required such agreements and affirmed their value. ODH Br. 7-8 (citing Medicaid requirement, 42 C.F.R. § 416.41(b), and statements from The American Association for Accreditation of Ambulatory Surgery Facilities and The American Congress of Obstetricians and Gynecologists). Thus, the Order correctly found that the Clinic did not satisfy the Rule.

Alternatively, the Clinic suggests it is entitled to a remand for a new hearing to show how it met the Rule. No such remand is justified. As shown above in Part A1, the Clinic knew the Rule was at issue and even said so; thus, it had notice and a hearing. This case raises no due-process concerns. *See* Clinic Br. 15-16. Moreover, because the Clinic already presented evidence that it thinks shows its Ann Arbor Arrangement and helicopter plan are good enough, it cannot point to any other evidence it *would* present in a new hearing to show compliance.

The same evidence addresses both the Rule and the Statute because the Statute did not change the standard, which always involved a "local" requirement as part of being effective in "emergency situations." As the Department noted, ODH Br. 19, the Sixth Circuit described the Rule in 2006 as "a requirement that ASFs have a written transfer agreement with a *local* hospital." *Baird*, 438 F.3d at 599 (emphasis added). The Clinic portrays that as a great change, but it cannot deny that the Rule required at least *some* notion of a geographic limit. While it at some points suggests that location cannot be a factor, Clinic Br. 13, it never contends that an agreement with a California hospital would be good enough. That shows that its disagreement is a matter of *degree*. While the Clinic disagrees with the then-Director's 30-minute standard (believing it should be longer), that disagreement does not render the Order invalid.

Finally, the Department again urges the Court to resolve this case solely upon the Rule and not reach the Statute at all. And if the Court disagrees, and reaches the Statute, it should uphold it against all challenges, but if the Court finds any problem with the Statute, it must still return to the Rule *after* any such finding, and uphold the Order in the end.

B. The Transfer Agreement Statute's inclusion in a budget bill did not violate the one-subject clause, as it is linked to the Variance Statute and Public Hospital Statute, both of which involve operation and management of state government.

The Transfer Agreement Statute does not violate the one-subject clause. *See* Ohio Const. art. II, § 15(D). *Only* the Transfer Agreement Statute is directly at issue, as the challenged Order

is based only on that (and on the Rule), and not on the Variance Statute and Public Hospital Statute. *See* Clinic Br. 22 (seemingly agreeing that "Capital Care did not raise these statutes in its appeal and neither statute was used . . . to revoke Capital Care's license"). That is, this is not a declaratory-judgment action against all three. If the Court opined that the latter two were invalid, but upheld the Transfer Agreement Statute, that would not affect the Order's validity: The Clinic did not seek a variance and did not have a willing public-hospital partner that was somehow blocked by the new law from signing an agreement.

In particular, the Clinic is mistaken when it suggests that the Public Hospital Statute *caused* the University of Toledo Hospital to let its agreement with the Clinic expire without renewal. *See* Clinic Br. 1 ("When the State prohibited the University of Toledo Hospital to have a written transfer agreement with Capital Care because the medical care it provided to women included abortions, the hospital rescinded the agreement with Capital Care."). As the Clinic elsewhere admits, Clinic Br. 4, that hospital told the Clinic in *April* 2013 that it would withdraw, months before the provision in the June budget bill was even proposed, let alone enacted—and it was effective in September 2013. That later-enacted law did not and could not *cause* an earlier event, of course, so that law is not at issue here.

Although the other two laws are not directly at issue, they can and should be considered as part of the context of the Court's one-subject review. The Court has held that multiple provisions can satisfy one-subject review if the provisions are reasonably linked to each other and *some* are budget-related. *OCSEA*, 2016-Ohio-478 ¶¶ 33-34. Considering those laws as context, although they are not directly at issue, is not having it "both ways," as the Clinic charges, Clinic Br. 22, but is simply following the Court's *OCSEA* reasoning. To be sure, as the Department acknowledged, ODH Br. 31-32, any potential invalidation of the Written Transfer

Agreement Statute would likely render the other two inoperative as a statutory matter, as the latter two are textually built upon the first. But such resulting invalidation would be distinct from striking them *as one-subject violations* themselves, which would be wrong procedurally, and would create bad precedent both as to that process and as to one-subject law.

The Clinic's one-subject challenge fails, primarily because it wrongly insists on a dollars-and-cents "budget" connection, Clinic Br. 19, 21, but a budget bill is more broadly about "balancing state expenditures against state revenues to ensure continued operation of state programs." *OCSEA*, 2016-Ohio-478 ¶ 23. So it fairly includes provisions "rationally related to budgeting for" operations. *Id.* at ¶ 33. *OCSEA* upheld a requirement to comply with operation and management standards because it helped "ensure the continued operation" of a state function. *Id.* at ¶ 30. To be sure, the operational provisions in *OCSEA* also had financial effects, leaving no doubt there, but operational provisions about how to deploy state resources are themselves fairly included in a budget/operations bill. The question, then, is not whether a provision has *financial* effects, but whether it is rationally related to ensuring the operation of a state agency or program, and overall, whether there are "practical, rational[,] or legitimate reasons for combining [the] provisions in one act." *Id.* at ¶ 17. Thus, the Clinic's insistence that none of these provisions involves spending directly, Clinic Br. 20, even if true, is not dispositive. And the Clinic does not, and cannot, deny that *operations* are involved.

Both of the unchallenged provisions involve state operations. The Public Hospital Statute literally tells public hospitals how to operate: Do not enter such agreements. And that instruction is part of a broader, long-established, and legitimate condition on state operations: The State itself does not wish to perform, pay for, or sponsor abortion. *See, e.g.*, R.C. 5101.57(A)(3), (B); *see Poelker v. Doe*, 432 U.S. 519, 521 (1977) (allowing such a condition for

public hospitals). It does not matter if public hospitals will accept emergencies that arise; the State does not wish to be an ongoing contractual partner with abortion clinics. Whatever the *policy* debate on that might be, such a decision is part of state *operations* of its own programs.

Likewise, the Variance Statute involves the Department's operations, and the Clinic does not seem to dispute that it does. Clinic Br. 21. Instead, the Clinic insists that is not enough, saying that all provisions must be "bound by the thread of appropriations," *id.*, excluding *operations* as part of the thread. It objects to the State's reliance on *Dix*, saying that *Dix* allows a budget bill to "bring[] greater order and cohesion to the law" on "a large number of topics" only if all changes "are germane to a single subject." *See State ex rel. Dix v. Celeste*, 11 Ohio St. 3d 141, 145 (1984). But "operations" are a subject, and just as a budget bill sets appropriations for many agencies, so, too, can it adjust operations for many agencies, or limit how state funds or resources are used. *Cuyahoga Cty. Veterans Servs. Comm'n v. State*, 159 Ohio App. 3d 276, 2004-Ohio-6124 ¶ 14 (10th Dist.) ("Restricting funding is as much a part of an appropriations bill as granting funds."). And it means nothing to object that these provisions are just a few lines in a "two-thousand-page budget bill," Clinic Br. 21, as that could be said of almost any budget-bill provision, whether a spending line or an operational one.

Finally, the Transfer Agreement Statute reasonably relates to the budget because it is linked to the other two operational provisions, and the Clinic's objections repeat its mistaken focus on dollars as opposed to operations. Indeed, the Clinic concedes that the three provisions link to each other and fit together in the same bill: "Had the General Assembly passed the three transfer agreement statutes in one bill, then the State's argument would be persuasive." Clinic Br. 22. The Clinic merely objects to *any* of these provisions being in the budget *and operations* bill. Indeed, the link here is *stronger* than in *OCSEA*. There, the Court found that the

operational provisions—"criteria and requirements" for contractors to operate prisons—helped the effectiveness of the separate prison-privatization provisions. 2016-Ohio-478 ¶¶ 27-30. Here, the related provisions are not merely *helpful*, but *necessary*. The Public Hospital Statute and Variance Statute Transfer cannot work without the Transfer Agreement Statute as a premise, as both build on the core requirement. True, the equivalent Transfer Agreement *Rule* already did the same thing, but as an agency rule, it might be repealed or modified, leaving the other provisions by themselves. Codifying it as statute makes the whole package, which again include operational aspects, work.

In sum, the Transfer Agreement Statute satisfies the one-subject rule and should be upheld, and the other two Statutes are relevant to the analysis but are not at issue. And again, the State is not trying to have it "both ways" with that distinction. Clinic Br. 22. To the contrary, the State's view clarifies that the Clinic needs *only* to show, if it could, that the Transfer Agreement Statute is a one-subject violation to undercut that law as a basis for the Order, and the other provisions are orphaned for future operation without it. But because the Transfer Agreement Statute *does* satisfy the one-subject rule, all three provisions remain valid.

C. The undue-burden issue was neither legally preserved nor factually supported, and remand is not justified.

After earlier acknowledging, rightly, that this case did not involve an undue-burden claim, the Clinic now mistakenly embraces this court-initiated issue. The Clinic asks this Court to opine on a federal constitutional issue with *no* factfinding below to support it, and in the alternative, the Clinic asks for a remand to develop this issue. The Clinic is wrong.

1. An undue-burden challenge must be properly raised *and* have extensive evidentiary support, and both are missing here.

The Clinic admits, as it must, that it never raised an undue-burden claim legally and factually. It said so to the appeals court: "Appellee has never argued at any stage of this case

that it has suffered a substantive due process violation and presented no evidence to that effect at the administrative hearing." Clinic's Sixth Dist. Br. 14 n.2. And it told this Court at the jurisdictional stage that it "did not seek a ruling in the common pleas court or the Sixth District as to whether Ohio's WTA statutory requirements violated substantive due process because it created an undue burden on abortion providers and patients." Opp. Jur. 8. But now, it says that the Court should find an undue burden, and that the lack of preservation and lack of evidence are no problem. That is wrong, as such a claim must be raised and proven.

First, the Clinic is wrong to say that "the State itself raised this issue before the Sixth District," and that "the State invited the Sixth District to rule on whether Ohio's licensing statute created an undue burden." Clinic Br. 30. The common pleas court, *not* the Department, raised the issue. That court began its analysis with the abortion-rights standards from *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 869, and *Roe v. Wade*, 410 U.S. 113 (1973). Com. Pl. Op. 2, App'x 2. It framed the issue in undue-burden terms: "The instant administrative appeal calls on the Court to review whether the State's attempt to exercise its important and legitimate interest in potential life *unduly burdens* the constitutional liberty to terminate pregnancy." *Id.* at 3 (quotations marks omitted; emphasis added). The court was *wrong* to say so, but it said it. And it blended the unraised undue-burden test with the delegation claim the clinic raised. *Id.* at 18. That analysis was no mere dicta; the court "[found] that the 'undue-burden' standard, addressed in [*Casey*], applies to the Court's inquiry into the constitutionality of" Ohio's law. *Id.* The Clinic told the appeals court that these statements were dicta or observations in passing, and that "the court did not apply *Casey*" and "made no holdings" under the undue-burden test. Clinic's Sixth Dist. Br. 14 n.2. The common pleas court's own words say otherwise.

Equally important, the Department did not "invite" the appeals court to rule on undue burden, but asked it to reverse and vacate the *common pleas court's reliance* on that issue, and to address the delegation theory as a non-abortion-specific due process claim. ODH Sixth Dist. Br. 11. And that is what the Department says here—that the undue burden issue should be set aside and not reached. True, the Department also notes that *if* the Court reaches the issue, it would have to reject such a claim for lack of proof, but that is just another reason that the Clinic ought to agree to set aside the issue, rather than endorse reaching an unlitigated issue.

The Clinic offers several justifications for reaching the issue, but none withstand scrutiny. *First*, it says that the "accordance with law" part of the administrative-appeal standard allows, and even *requires*, courts to consider any development in "law" that might affect an agency order. Clinic Br. 22-23. That is wrong, as it would discard the normal rules for preserving issues in *all* administrative appeals; any administrative appellant could raise any new issue any time.

Second, the Clinic is not helped by noting that courts "consider new law when a case is pending on appeal." *Id.* at 24 (citing *State v. Moore*, 149 Ohio St. 3d 557, 2016-Ohio-8288 and *Ohio v. Crager*, 123 Ohio St.3d 1210 (2009)). Those cases involved new case law affecting an *already-raised issue*; they did not allow a *new, unraised claim* because a new case considered it.

Third, the Clinic's reliance on *Hellerstedt* is misplaced, as that decision re-affirms the need for an extensive factual record, in sharp contrast to the Clinic's new claim that no record is needed. *Whole Women's Health v. Hellerstedt*, __ U.S. __, 136 S. Ct. 2292, 2309-12 (2016). *Hellerstedt* explained that "the Court when determining the constitutionality of laws regarding abortion procedures, has placed considerable weight upon *evidence and argument presented in judicial proceedings*." *Id*. at 2310 (emphasis added). In particular, "the rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access," based on that

factual record, balanced against the "the benefits those laws confer." *Id*. at 2309; *see also id.* at 2311 (listing record evidence supporting its ruling). Here, no evidence at all was presented about the burden or benefit side, let alone the type of detailed record reviewed in *Hellerstedt.*

As to burden, the Clinic asks the Court to take a great leap in abortion law in saying that applying the law to this Clinic would leave women seeking abortion "would be forced to travel" to Cleveland or Columbus. Clinic Br. 26. That ignores closer abortion clinics in Detroit and Ann Arbor. Indeed, the Clinic paradoxically insists that Ann Arbor is close enough for *emergencies*, but should not be considered a comparative destination for routine, non-emergency procedures. *Cf. Baird*, 438 F.3d at 606 (finding no undue burden if closing Dayton abortion clinic would cause women to travel an hour to Cincinnati).

As to benefit, the Clinic criticizes the *Department* for lack of evidence: "The State chose not to present evidence to justify the transfer agreement provision." Clinic Br. 27. That is, the Clinic should be allowed to embrace a claim that it never supported, and the *State* should have known to present evidence defending against an unraised claim just in case it arose later. That is not only absurd in principle, but creates an even more absurd result: Every agency, in every factbound hearing, would need to present mountains of evidence justifying whatever regulation is at issue to ward off unraised claims on appeal. And courts have noted the benefits of transfer agreements, as distinct from admitting-privilege laws such as Texas's. *Baird*, 438 F.3d at 607, 609; *Planned Parenthood of Wisc., Inc. v. Schimel*, 806 F.3d 908, 922 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545 (2016) (invalidating admitting-privilege law partly because prior transfer-agreement requirement validly served medical interests already).

Reaching the undue-burden issue would require the Court to decide the threshold issue of whether undue-burden analysis even applies to abortion-neutral laws. ODH Br. 36-39. The

Clinic says it applies, but its citations do not support that. *Hellerstedt* did not involve solely abortion-neutral laws; it involved some, but they were blended with abortion-specific laws. For example, even Texas's requirement for abortion clinics to meet the "same standards" as other clinics came with the abortion-specific twist that abortion clinics, unlike other clinics, could not seek waivers from any rule. *Hellerstedt*, 136 S. Ct. at 2315. Indeed, Justice Ginsburg described the Texas law as specially "[t]argeted" at "[a]bortion [p]roviders." *Id.* at 2321 (Ginsburg, J., concurring). The Court should not address such an important issue without proper development.

2. No remand is justified, as the Clinic could have raised such a claim but did not do so.

The Clinic's alternate suggestion—that the court remand to the trial court so the Clinic can develop an undue-burden claim, Clinic Br. 31—is wrong. The Court has never allowed, and should not start to allow, remand in an administrative appeal to raise an unraised issue, as opposed to issues that had been part of the case all along, and were unresolved, or need to be reconsidered under a new test. And the Clinic's suggestion of remand to the common pleas court, because an agency cannot *resolve* a constitutional issue, would be a sharp break with the settled rule that a party must still *preserve* a constitutional claim with evidence and law at the agency level. *City of Reading v. Pub. Util. Comm.*, 109 Ohio St. 3d 193, 2006-Ohio-2181 ¶ 16.

The Clinic has known all along that it could have raised an undue burden claim, but it chose not to. Two other clinics *have* filed undue-burden and delegation claims against Ohio's laws. Clinic Br. 8 n.2. The Court should not upend normal procedure now to accommodate the Clinic's regrets about its litigation choices.

D. The Clinic's delegation claim is mistaken.

Finally, the Transfer Agreement Statute does not unconstitutionally delegate licensing authority to private hospitals by requiring all surgical facilities, not just abortion clinics, to

contract for emergency care. Clinic Br. 32-43. Notably, the Clinic admits that this claim is not abortion-specific, and that its view would invalidate the law for *all* surgical facilities. The Department showed why this is not a "delegation," and why delegation doctrine should not be extended to cover it. ODH Br. 41-50. The Clinic's contrary arguments fail.

First, the Clinic's view greatly expands a *Lochner*-era doctrine. *Id.* at 41-47. No federal circuit court has used delegation theory to invalidate an abortion law, let alone a neutral law like Ohio's. Even if the Transfer Agreement Statute "delegated" power (it does not), the doctrine concerned legislatures delegating *lawmaking* power to private parties. Such power is not infringed here because the General Assembly, not hospitals, set standards. Expanding that doctrine beyond its separation-of-powers roots would, as the U.S. Supreme Court said in refusing to expand the doctrine, threaten "[a]lmost any system of private or quasi-private law." *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 439 U.S. 96, 109 (1978).

The Clinic relies on *Lochner*-era cases, Clinic Br. 32-33, but that line of cases largely dead-ended in three cases in the 1930s to 1940s that confirmed legislative authority, ODH Br. 41-42. The Clinic does not distinguish or cite those cases, nor does it suggest that the General Assembly may not set safety rules for surgical clinics. It says that power is "not relevant" here, Clinic Br. 40, but it is precisely that legislative power to set standards for medical facilities, *cf. Women's Health Ctr. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989), that is at issue.

The remaining cases the Clinic cites also do not support its view. Clinic Br. 33-35. *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), is about spousal and parental consent laws. *Danforth*'s underpinning was that the State itself has no power to veto abortion, so it has nothing to delegate to a spouse or parent. Further, *Danforth* relied on pre-*Casey*, *Roe* standards. *Id.* at 69. And *Tucson Woman's Clinic v. Eden*, 379 F.3d 531 (9th Cir. 2004), ultimately rejected

a delegation claim. The district court cases the Clinic cites rely on *Roe*'s discarded, strict-scrutiny, first-trimester test, and the more recent case, Clinic Br. 34, relies on the earlier ones. More important, the Clinic fails to explain how *abortion law* invalidates a law for *all* ambulatory surgical facilities.

Second, as the Fifth and Eighth Circuits have explained, statutes like this one do not delegate power at all. Ohio requires surgical facilities to meet certain health-and-safety requirements, including requiring those facilities to show that they have access to emergency medical care. Surgical clinics get that service from a hospital, just as they get other needed goods and services from third-party suppliers. That does not mean that hospitals or other suppliers exercise a licensing veto. Just as a medical facility cannot operate if it cannot retain a doctor, so it cannot operate if it cannot provide access to emergency care. *See Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 600 (5th Cir. 2014); *Webster*, 871 F.3d at 1382.

The Clinic's response doubles-down on defining delegation broadly, suggesting that requiring clinics to use licensed doctors *is also* a delegation, made constitutional only because "the licensing body must follow" due process. Clinic Br. 42-43. But the problem with the Clinic's view is not about the *licensing body* using process, but that those bodies often require private exams or education requirements from parties that do not use due process. Separately, the Clinic's view would find a delegation problem in that all *doctors* (not just hospitals) might refuse to work with a clinic, but that does not invalidate requirements that only doctors do surgery. The same is true of any required services, like if all drug companies refused to sell a clinic anesthesia.

Third, as the Fourth and Sixth Circuits have explained, reaching these core delegation questions is unnecessary if the State retains authority to grant a license even if a surgical clinic does not have a Transfer Agreement. *Baird*, 38 F.3d at 610; *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 317 F.3d 357, 362 (4th Cir. 2002). The Clinic mistakenly says the Statute "eliminated" that retained authority, but the Statute simply codifies conditions for variances and eliminates waivers. Clinic Br. 37; R.C. 3702.304. The Clinic says that the Rule allowed the Director to issue a variance or waiver for "any reason he saw fit," but the Statute "eliminated the Director's discretion." Clinic Br. 37-38. Not so. The Rule allowed variances only if the transfer-agreement purpose was "met in an alternative manner," and waivers only if doing so would "not jeopardize the health and safety of any patient." *Baird*, 438 F.3d at 599. In practice, the Department had long required what the Statute now codifies: "the names of the back-up physicians, their credentials, and admitting privileges at" local hospitals. *Id*. at 602. *Baird* upheld that. And *Baird* did not say that variances "saved" the Rule, Clinic Br. 32, but only that it "need not decide" if delegation theory was valid, as the variance/waiver option *would* defeat such a claim if valid. 438 F.3d at 610.

And any alleged change from the Variance Statute does not invalidate the Transfer Agreement Statute, and again, the Order did not rely on the Variance Statute because the Clinic never sought one.

* * *

Again, while all of the Clinic's constitutional challenges to the Statute fail, the Court need not reach them. It should apply the Rule and uphold the Order.

CONCLUSION

The Court should reverse the Sixth District and affirm the Director's Adjudication Order.

Respectfully submitted,

MICHAEL DEWINE (0009181)
Ohio Attorney General

/s Eric E. Murphy
ERIC E. MURPHY* (0083284)
State Solicitor
**Counsel of Record*
STEPHEN P. CARNEY (0063460)
PETER T. REED (0089948)
Deputy Solicitors
RYAN L. RICHARDSON (0090382)
TIFFANY L. CARWILE (0082522)
Assistant Attorneys General
30 East Broad Street, 17th Floor
Columbus, Ohio 43215
614-466-8980
614-466-5087 fax
Eric.Murphy@OhioAttorneyGeneral.gov

Counsel for Appellant,
State of Ohio Department of Health

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Reply Brief of Appellant State of Ohio Department of Health was served by regular U.S. mail and e-mail this 8th day of August 2017, upon the following counsel:

Alphonse A. Gerhardstein
Jennifer L. Branch
Gerhardstein & Branch Co., L.P.A.
441 Vine Street, Suite 3400
Cincinnati, Ohio 45202
jbranch@gbfirm.com

Terry J. Lodge
316 N. Michigan Street, Suite 520
Toledo, Ohio 43604-5627
tjlodge50@yahoo.com

Counsel for Capital Care Network of Toledo

/s Eric E. Murphy
Eric E. Murphy
State Solicitor