Acquisitions and Partnerships Between Secular and Catholic Health Organizations: Navigating the Canonical, Ecclesial and Theological Considerations

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ABSTRACT

Today, one in seven Americans in need of hospital care will receive it in one of over 650 Catholic hospitals in the United States.[1] According to the American Hospital Association, Catholic hospitals represent over 10% of the 6,093 total hospitals in the country.[2] One in six hospital beds in the United States are now affiliated with a Catholic hospital system.[3] These numbers demonstrate the sizeable percent of market share of Catholic healthcare. In an era of fierce competition in healthcare, this is an invitation for secular and Catholic health care partnerships. However, these potential partnerships invite an understanding of deeply held beliefs in the Catholic tradition. This essay encourages secular and Catholic health system mergers, acquisitions and partnerships and will offer a clear guide for navigating the ethical, canonical and ecclesial considerations for such an acquisition. These considerations are "the four Ps": the principle of cooperation, paper, people and process.

INTRODUCTION

As the cost of competition for resources, equipment, patient volume, physicians and employees increase, many hospital executives must consider mergers with competitors or end up closing. Since 2011, more hospitals have closed than opened with rural communities often being most affected by these closures.[4] In 2016, 15 of the 21 hospitals that closed were in rural communities and since 2010, nearly 90 rural hospitals have closed.[5] Mergers, however, represent an alternative to closure.

In the 20 years between 1998 and 2017, there were nearly 1,600 hospital mergers.[6] With rural populations shrinking, services shifting to outpatient settings and rural areas experiencing lower incomes and higher rates of uninsured people resulting in higher levels of uncompensated care, some markets are not able to sustain multiple hospitals. In these markets, competing hospitals will either continue the competition until only one entity remains or

they must explore mergers, partnerships or acquisition opportunities. Healthcare executives point to limited capital, technology costs, repairing aging infrastructure and financial performance as reasons to consider merger and acquisition activity.[7] The tax-exempt nature of religious-based organizations also represent a most attractive advantage.

Catholic hospitals face these same challenges. Believing in their mission, leaders of Catholic hospitals have to confront the same economic and market challenges their secular competitors are facing. Certainly, the shift in care and reimbursement as well as the reduction of women and men religious congregations that have traditionally sponsored these ministries have also had its impact on Catholic healthcare.[8] While wanting to maintain their Catholic identity, leaders of Catholic healthcare seek opportunities for partnership and even acquisition for similar business and financial reasons. Opportunities for Catholic hospitals to partner or be acquired by a secular health system are increasing. There are growing examples of Catholic hospitals belonging to secular health systems in order to sustain their faith-based mission in the current marketplace.[9] However, in order for these partnerships to emerge, it is critical to understand the "four Ps": the principle of cooperation as well as the important paper, people and processes to be navigated.

PRINCIPLE OF COOPERATION

A basic understanding of the moral principle of cooperation in the context of Catholic moral theology is essential in understanding the considerations to complete a transaction in which a secular health system would acquire a Catholic hospital. At its core, the principle of cooperation considers the moral boundaries of cooperation and partnership in human activities when moral commitments may not align. For example, certain procedures that could be classified as contraception or sterilization might be viewed by some practitioners as essential to the services they provide to their patients whereas other practitioners might view it as a violation of the dignity of the person. The principle of cooperation seeks to describe the complex nature of human activity to determine when one's actions are considered too proximate or close to a collaborator's actions such that their participation would constitute a failure to live up to one's moral commitments.

The principle of cooperation describes the relationship between the "doer" of the action and the "cooperator" with the action. In the framework of Catholic moral theology, the "action" would be that which could be considered a moral "evil". The "doer" of the action is the one who initiates and directly intends the specific action. The "cooperator" of the action is only involved in the action in some way separate -or at a moral distance- from the "doer" and may not "intend" the evil, but merely tolerates it in order to achieve some specific good.[10] For example, if a secular health system (the "doer" in this case) performed services such as contraceptive procedures that would be prohibited within a Catholic hospital, that could constitute a moral evil from the perspective of Catholic moral theology. The Catholic hospital (the "cooperator" in this case) would have limits related to its participation in this action. An acquisition of the Catholic hospital by a secular health system to achieve some good for the community would need

to ensure that any potential participation of the Catholic hospital in this perceived evil would meet the standard required for morally acceptable cooperation in that act.

The principle of cooperation does not stop this relationship from happening but, rather, serves as a tool for its moral assessment. There are two distinctions to note when considering the principles governing morally legitimate cooperation with an action: the first is between "formal" and "material" cooperation and the second further distinguishes "material" cooperation between "immediate" and "mediate" material cooperation.

First, to the formal and material distinction: if the cooperator participating in the "wrongdoing" intends the wrongdoing, then that cooperation would be considered "formal" cooperation and would be morally wrong. In the example above, if a nurse helping in a sterilization procedure, such as a tubal ligation, wants the operation performed, it would be formal cooperation and would be illicit. It is for this reason, for example, that the Vatican stated no Catholic healthcare facility could ever formally cooperate in providing sterilization.[11] If the cooperator does not intend the wrongdoer's actions, then the cooperation is considered "material" cooperation. Moral theologians have argued that material cooperation can be morally licit pending other issues and distinctions.[12]

To the second distinction between "immediate" and "mediate" material cooperation: immediate material cooperation is when the object of the cooperator is the same as the object of the wrongdoer and, as such, is usually always morally wrong.[13] However, when the object of the cooperator's action remains different and distinguishable from that of the wrongdoer's then it is "mediate" material cooperation and can be morally licit.[14] For example, if the secular health system provided various procedures intended for the purpose of sterilization, the Catholic hospital should still be able to be part of this secular health system as long as the Catholic hospital's actions are seen as completely separate from the procedure resulting in the sterilization. Specific steps can be taken to ensure the proper separation is present such as

- separate billing for that procedure
- separate procurement of supplies for the procedure
- the procedure occurring in a space not owned or directly leased by the Catholic entity
- physicians not being employed or paid by the Catholic hospital at the times while performing the sterilization procedure.

These steps ensure that the material cooperation of the Catholic hospital is at an acceptable level, that is, mediate material cooperation.

PAPER

Catholic healthcare follows all applicable civil laws at the municipal, county, state and federal levels. In addition, "church law", known as Canon Law, governs the Catholic Church around the world, including particular aspects of Catholic healthcare as related to the property and apostolates of the Church.[15] Local countries also have national "conferences" that direct

the life of the Church more specifically in that country. In the United States, the United States Conference of Catholic Bishops (USCCB) has proscribed national guidelines that direct the exercise of Catholic healthcare within the United States.[16] This document, the *Ethical and Religious Directives for Catholic Health Care Services in the United States* (ERDs), along with universal Canon Law, gives guidance in mergers, acquisitions and partnerships between Catholic and secular hospitals and health systems.[17] Finally, original articles of incorporation are important to secure as it will detail the nature of the hospital's property and assets, the "sponsor" of the local Catholic hospital ministry and any "reserved powers" the sponsor may retain. These details are important as it will determine the proper "people" and "process" that will need to be subsequently engaged. In sum, canon law, the ERDs and the original articles of incorporation are three important documents -the "paper"- that will be critical in navigating mergers, acquisitions and partnerships of this kind.

PEOPLE

In these potential arrangements, there are important people in the Church that would be involved in any potential merger, acquisition or partnership with a Catholic hospital or health system including the Bishop, the "Sponsor", the Holy See, the Catholic hospital CEO and the local mission executive who serves as a liaison between all the parties. In addition to both canon and civil lawyers, these four roles are critical in navigating the canonical and ecclesial processes required to achieve such transactions.[18]

Bishop

The local Diocesan Bishop is one of the most important persons to engage. The Bishop is the coordinator of all ministries within the Diocese (canon 394),[19] and is to be consulted in matters of import to the Catholic hospitals in the Diocese. The United States Conference of Catholic Bishops note, "the bishop has the right and responsibility to exercise his authority over all apostolates in his diocese including that of health care (canon 678)".[20] The ERDs specifically note the role of the local Diocesan Bishop (directive #68, 69).[21] He may delegate others to assist him in this task.[22] In some cases, his permission is required; in other cases, such as that which might be reserved to the Holy See, his nihil obstat, a statement that denotes he has no objection and approves the petition, would be required.[23]

In addition to internal matters of the Church in which the diocesan bishop has authority, he has an equally important role in civil matters as well which is critical for any health system to recognize. For example, the IRS' "group ruling" allowing all entities in the "Official Catholic Directory" to be recognized as a `religious (Catholic) organization' - and, therefore, tax exempt is important here. Inclusion in this Directory is at the sole discretion of the Bishop. Therefore, honoring the "Catholic Identity" of the hospital and nurturing the relationship with the Bishop is also critical from a civil law and tax-exempt perspective.[24]

Sponsorship

Sponsorship in Catholic healthcare is the formal relationship between a Catholic organization and its various entities, including,

for example, its Catholic hospitals. Sponsors are responsible for the viability, mission and life of the ministry they serve.[25] Sponsors are not necessarily "owners".[26] Most often, the Sponsor has certain, specific, "reserved powers" including the rights to purchase or sell its apostolates and corresponding property and assets.[27] The Sponsor is often the one who can green-light the potential acquisition of one of its hospitals by another health system. Traditionally, sponsors were members of a Religious Institute who, living out the charisms unique to their identity, founded various schools, centers of justice and hospitals (canons 678, 680).[28] More recently, there are new methods of sponsorship expressed in various models including lay-formed `juridic persons' who are recognized in the law (canons 315, 676).[29]

Juridic Persons are created by law or decree to carry out a part of the mission or work of the Church.[30] A Public Juridic Person (PJP) can come into existence by decree or by the law itself, can act in the name of the Church and can own ecclesiastical property following all the norms prescribed in the law.[31] Ecclesiastical property is basically "church property" and many Catholic hospitals might be considered such. A Private Juridic Person does not act in the name of the Church and maintains ownership of its own property but can still offer apostolic work or charity.[32] The Juridic Person is often comprised of lay leadership (canon 298§1).[33]

The Juridic Person is important when the Catholic partner must navigate matters related to transferring sponsorship, alienating assets or engaging in other matters governed by canon law. For non-Catholic partners, it is important to identify who the "competent ecclesiastical authority" would be in the respective case (canon 116 §1).[34] If the PJP is of "Diocesan Rank", the competent ecclesiastical authority is the local Diocesan Bishop. However, if it is of "Pontifical Rank", the authority would be the Holy See.[35]

The Holy See

The Holy See is the `government' of the Roman Catholic Church in the Vatican. When the Holy See might need to be engaged, the mission executive of the Catholic healthcare organization can serve as intermediary, working with competent civil and canon lawyers as well as the Holy See's local "ambassador" in the country, called the Nuncio. A petition (that is, a request for an "Indult") related to alienation of stable patrimony (that is, ecclesiastical property that is part of the Religious Organizations assets dedicated to some service or apostolate) would be directed to one of the dicasteries (that is the particular congregation or office) of the Holy See related to the case in question. In a matter such as the acquisition of a Catholic hospital, the appropriate dicastery would be the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life (CICLSAL).[36]

Mission Executive

Mission executives are entrusted with guiding administrators of Catholic healthcare institutions in the spiritual, ethical, cultural, moral and canonical issues involved in leading Catholic health care.[37] The mission executive would be a key asset in navigating the relationships and nuances of transactions governed by canon law and should, therefore,

have knowledge of the structure and type of Juridic Person that sponsors the ministry in question. The mission executive can help interface between the bishop, the sponsor, the various civil and canon lawyers and the healthcare executives from both parties.[38] Key questions the mission executive navigates might include whether the Catholic hospital is part of a public or private juridic person; of diocesan or pontifical rank; the kinds of ecclesiastical goods that are owned by that public juridic person (if applicable); if the assets are part of a stable patrimony; and what inventory of property/ ecclesiastical goods the organization possesses. The answers to these questions determine the course of action, or the `process' for the acquisition to occur.

PROCESS

After encouraging the mutually beneficial imperative warranting consideration of an affiliation between a Catholic hospital and a secular health system, discussing the principle of cooperation and sharing information on important paper (Canon Law, ERDs, Articles of Incorporation) and people (Bishop, Sponsors, Holy See, Mission Leaders), this essay will now present a basic overview of a process to be followed in order to complete this acquisition.

In order to achieve the endorsement of the local Bishop (his nihil obstat), early and regular communication with his office will be essential. This is often done between the Vicar for Healthcare and the local Catholic hospital's lead mission executive. The bishop will often have two areas of focus that are important – a commitment to the poor and an assurance that the non-Catholic health system will continue to operate the Catholic hospital(s) as Catholic.

Required assurances related to maintaining the Catholic identity of the hospital can be negotiated with the office of the Bishop. Usually, the items to which the Bishop would request include continuing to follow the ERDs, a regular audit (or update) to ensure compliance, the establishment or continuation of the role of the mission executive, the promise to staff the hospital with a qualified chaplain(s), a commitment to serve the poor and vulnerable and an ongoing formation plan to integrate spirituality into the workplace. Ensuring the Catholic culture is the normative culture and moral code of the Catholic hospital is paramount for the Bishop. The provision of funds to sustain a viable Mission Office and Chaplain Services would be a measurable way to confirm these assurances and might be requested by the bishop. Adherence to the ERDs could be ensured by including a provision for compliance in the transaction documents.[39]

Within these documents, a category listed as "Maintaining Catholic Identity" could include language such as:

- The position of Vice President of Mission will be funded and staffed in perpetuity
- A well-staff Pastoral Care Department with certified chaplains will be maintained
- Adherence to the *Ethical and Religious Directives of Catholic Health Care Services* in the United States published by the United States Conference of Catholic Bishops will be followed within the Catholic entity and by all employees of the Catholic entity with careful attention to the principle of cooperation

- The Catholic Hospital will maintain its commitment to the care of the poor and vulnerable through its charity care function and other community benefit work

Maintaining the Catholic identity of the hospital also has important civil considerations for the health system. Any change in the religious identity of the hospital might risk termination of its exempt status and all the benefits that come with it (property tax exemption, church plan treatment for certain employee pension/benefit plans, ERISA exemptions, etc.…)[40] Attorney Michael DeBoer of Faulkner University wrote a compelling article for the Seton Hall Law Review which encourages religious organizations to lean into their religious identity not only for the sake of their own mission but to ensure governmental and regulatory recognition of that religious identity in order to verify the various tax and other ministerial exemptions claimed to the benefit of the religious organization.[41]

Finally, with all this in place, it would be equally imperative to draw up a satisfactory communication plan. Bishops are very concerned with the potential for scandal. Scandal, in this specific context, is an occasion that might lead someone to believe an immoral action is not wrong.[42] For example, if a Catholic hospital was viewed as participating in a moral evil, it might lead one to believe that the action is not wrong since it is allowed in the Catholic entity. In turn, this might lead someone to participate in that sin, believing the wrong is not, in fact, sinful. So, even if great detail is spent to ensure Catholic identity and ERD compliance of the Catholic hospital, the public, otherwise unaware, might be confused as to if the Catholic hospital, now part of a secular health system is or is not operating as a Catholic hospital. Communication is essential to assure the community and the Bishop that the potential for scandal has been minimized.[43]

CONCLUSION

There are urgent challenges confronting health care, including both secular health systems and Catholic hospitals. These challenges invite a new consideration of mergers, acquisitions and partnerships between secular and Catholic health systems. These transactions might better serve the community, advance the viability of both the secular and Catholic hospitals by drawing on economies of scale, improving access to capital and minimizing a mutual self-destruction by continued competition in the community. It also allows the Catholic hospital to continue its sacred mission, a millennia old effort begun by their foundresses, the Women Religious, who came and dedicated themselves to the local community.

Adhering to the principle of cooperation and engaging the important paper, people and processes necessary will allow this acquisition to occur and enable the continuation of a stronger and more vibrant opportunity to serve the local community for generations to come. ✠

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