

Catholic Identity and the Reshaping of Health Care in the United States

Editor's Note: The process and tools accompanying this article were developed primarily by Michael Panicola. Given the number of mergers and affiliations occurring in Catholic health care, these materials might be of help to others in the ministry. The explanation of the process refers to 4 Appendices. Only two are included here—the 1st and 3rd. A summary of this article, the narrative explanation of the process and all four Appendices will appear in the September-October issue of Health Progress. The third Appendix consists of a grid illustrating an application of the Principle of Cooperation. Because principles involve judgments in a particular set of circumstances, it is quite possible that others might come to different conclusions than those illustrated in the grid. Furthermore, a revision of Part Six of the Ethical and Religious Directives that is currently in development could also affect the application of the Principle of Cooperation to new mergers and affiliations.

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Health care in the United States is in the midst of a major transformation, the likes of which perhaps we have never seen, not even in the oft-mentioned reform era of the 1990s when managed care rose to prominence. As stated in a white paper by the health care consultancy, Oliver Wyman, “We are at the beginning of the largest industry transformation in the past century...”

Traditional providers and new entrants – spurred by government, employers, and individuals – “are igniting a *volume-to-value revolution*” that will result in a radically different health care system than the one we know today (Tom Main and Adrian Slywotzky, “The Volume to Value

Revolution,” Oliver Wyman, 2013). The wheels are already in motion as payers are beginning to adopt value-based reimbursement models; employers are demanding more return on their considerable investment in employee health; providers are consolidating and forming strategic partnerships with an eye toward greater integration; consumers are becoming more cost-conscious as their share of the health care bill increases; start-ups and deep-pocket technology companies are challenging the status quo; and price transparency advocates are exposing the irrationality of a wide variation in health costs.

Encouraging Trends

Much of what we are seeing is encouraging, especially:

- The shift to population health with a focus on wellness, prevention, care coordination and chronic disease management;
- The development of new delivery structures and the proper alignment of financial incentives toward value and away from volume;
- The significant drop in the number of uninsured Americans as a result of the improving economy, Medicaid expansion and health care marketplaces offering individual and family plans made affordable through premium subsidies that were fortunately spared in the recent U.S. Supreme Court’s decision in *King v. Burwell*.

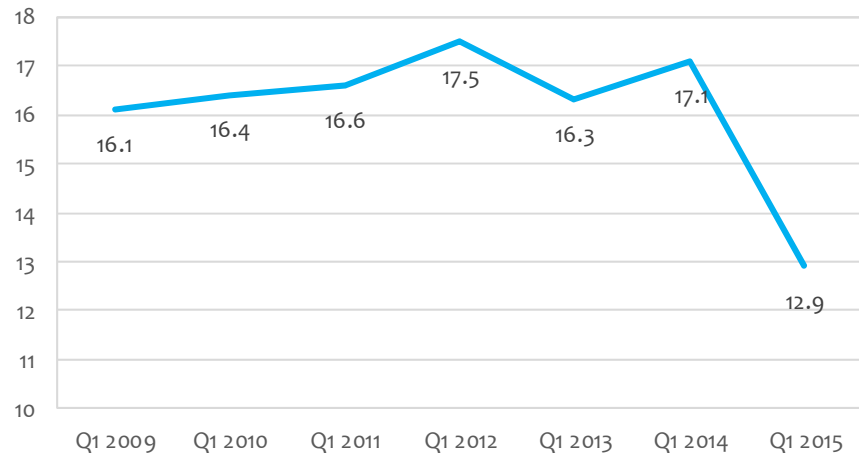
These are not only encouraging trends for U.S. health care in general but also for Catholic health care in particular as they hold the promise of creating a more just, sustainable health care system in line with a Catholic-Christian vision of health care. In fact, “the shift to population health and the development of delivery structures to enact this shift actually begin to embody some of the fundamental commitments of Catholic health care. Therefore, they have the potential for strengthening and realizing Catholic identity” (“Catholic Identity, Ethics Need Focus in New Era,” *Health Progress*, May-June 2013).

Concerning Trends

However, there are concerning trends as well. At the same time the percentage of uninsured is declining, the number of underinsured is increasing as close to

40 percent of individuals under 65 years of age now have a high-deductible health plan, defined as plans with deductibles of at least \$1,250 for single coverage and \$2,500 for family coverage. While these individuals may have health coverage, many cannot

Percentage of U.S. Adults >18 Years Without Health Insurance, by Quarter



Source : GALLUP Feb. 2015

afford to meet their deductible and as a result delay necessary care or go without needed medications. According to a recent survey by the Commonwealth Fund, approximately three out of five non-elderly insured individuals with low incomes and two out of five with moderate incomes reported that their deductibles are difficult to afford (Sara R. Collins et al., “Too High a Price: Out-of-Pocket Health Care Costs in the United States,” The Commonwealth Fund, November 2014). This problem is stretching beyond low- and moderate-income individuals as the average annual out-of-pocket health care expenses all non-elderly insured individuals incur annually has reached its highest point at \$5,000 and, correspondingly, the percentage of household income that goes to pay health care has been on the rise and for many is over 10 percent.

The concerns do not stop here as health care providers, too, are experiencing challenges of their own. The three major credit rating agencies maintained their negative outlook for the health care

sector in 2015 and singled out not-for-profit health systems, particularly, because of rising expenses and weaker reimbursements that will continue to put downward pressure on operating margins (see, for instance, Robin Respaut, “Grim Outlook for Healthcare, Hospital Sector in 2015: Rating Agencies,” *Reuters*, December 16, 2014). This has led, in part, to a rash of mergers and acquisitions with highly capitalized, larger health systems getting stronger, while less-capitalized, smaller health systems and free-standing hospitals get weaker, especially rural and critical access hospitals. There are many examples of this merger mania in health care, including: Community Health Systems’ purchase of Health Management Associates for \$7.6 billion making it the largest system by number of hospitals with more than 200 in 29 states and over \$18 billion in net patient revenue; and Tenet Healthcare’s \$4.3 billion acquisition of Vanguard Health Systems creating a system with over \$16 billion in net patient revenue (*Modern Healthcare’s* 2015 Hospital Systems Survey). Catholic health care has its own examples as we have seen the rise of mega-Catholic systems with revenues close to or surpassing those of the systems noted above and the proliferation of Catholic and non-Catholic partnerships.

The rapid consolidation in health care is hardly unique in the business world. Other industries that have undergone transformations of their own have experienced this same phenomenon – think banks, airlines, cell phone carriers, and car manufacturers. And, as many financial analysts and the rating agencies tell us, it may indeed be necessary as size and scale will be critical for future success. Still, when it comes to Catholic health care, we have never been in this for the money or merely to survive. It has always been or at least should be about our ability to further the healing ministry of Jesus by living out our fundamental value commitments, which are the true measure of our identity and are at stake in every

merger, acquisition, and partnership. But are we considering the impact on identity at this time when Catholic health care is being reshaped in unprecedented ways? Or, in our desire to ensure long-term sustainability, are we “chasing the market,” blindly accepting the practices and strategies the market dictates and unwittingly failing to consider what impact this has on identity? Are we asking how growth opportunities further our ability to live out our fundamental value commitments? Or, are we largely bypassing these concerns and only focusing on the narrower cooperation issues that could derail the transaction?

Fundamental Value Commitments

The business nature of health care today may make it easy to overlook the fact that Catholic health care is motivated, first and foremost, out of its faith in the redemptive act of Jesus Christ, which, as Henry Sigerist describes, causes us to see things in a different light:

In Jesus “the Christian faith introduced the most revolutionary and decisive change in the attitude of society toward the sick. Christianity came into the world as the religion of healing, as the joyful Gospel of the redeemer and of redemption. It addressed itself to the disinherited, to the sick and the afflicted, and promised them healing, a restoration both spiritual and physical” (*Civilization & Disease*, 1943, pp. 69-70).

Viewed through this lens, Catholic health care’s mission is and will always be to reveal God’s healing and reconciling presence to the sick and suffering of the community. This mission commits us to certain values and corresponding behaviors, namely: respecting the dignity and sanctity of human life;

providing compassionate, holistic care to those in need; promoting the health and well-being of the community; caring for those living in poverty and at the margins of society; exercising responsible stewardship of natural, human, and financial resources; advocating for and acting on behalf of justice; and contributing to the common good. These fundamental value commitments, which are rooted in the Gospel, are known throughout Catholic health care. Indeed, they are encompassed in the organizational documents of Catholic health ministries and make up the substance of the Catholic Health Association's Shared Statement of Identity. Yet despite this, the urgency placed on consolidation today may be muting our sensitivity to these fundamental value commitments as we strive to keep pace in the increasingly competitive health care marketplace.

As we pursue new business arrangements, we have to ensure we are really and truly advancing the mission of Catholic health care. This requires that we remain vigilant and deliberate about our fundamental value commitments and about who we are as ministry. An added reason to do this is the call of Pope Francis, who has challenged the entire Catholic-Christian community to a deepened living out of the Gospel values. Although he may not be explicitly addressing Catholic health care, the pope has taken up certain themes that reorient us to core aspects of our fundamental value commitments, aspects that must be taken into account when considering a merger, acquisition, or partnership if we are to advance the mission. In what follows, we will outline three such themes and highlight some of the implications for us within Catholic health care as we navigate our way through these uncertain times.

The Challenge of Pope Francis

What We Must Be – A Sign of Mercy and Hope

The first theme is that of mercy and hope. From the beginning of his papacy, Pope Francis has preached

that the church mediates God's love of humanity by being a sign of mercy and hope, especially to people who are suffering, lost, and in need of help. As the pope explains:

“[B]eing the Church, to be the People of God, in accordance with the Father's great design of love, means to be the leaven of God in this humanity of ours. It means to proclaim and to bring God's salvation to this world of ours, so often led astray, in need of answers that give courage, hope and new vigor for the journey. May the Church be a place of God's mercy and hope, where all feel welcomed, loved, forgiven and encouraged to live according to the good life of the Gospel. And to make others feel welcomed, loved, forgiven and encouraged, the Church must be with doors wide open so that all may enter. And we must go out through these doors and proclaim the Gospel” (Pope Francis, “General Audience,” St. Peter's Square, June 2, 2013).

While Pope Francis is speaking of the church as a whole, his words have special relevance for Catholic health care and remind us of the memorable pastoral letter on health care by the late Cardinal Joseph Bernardin in which he stated quite similarly that: “As Christians, we are called, indeed empowered, to comfort others in the midst of their suffering by giving them a reason to hope. We are called to help them experience God's enduring love for them” (Cardinal Joseph Bernardin, “A Sign of Hope: A Pastoral Letter on Healthcare,” October 18, 1995).

To do this – be a sign of mercy and hope – Catholic health care needs to be where the suffering is and ministering to those who are suffering. Pope Francis describes this well:

“I see clearly that the thing the church needs most today is the ability to heal wounds and to warm the hearts of the faithful; it needs nearness, proximity. I see the church as a field hospital after battle. It is useless to ask a seriously injured person if he has high cholesterol and about the level of his blood sugars! You have to heal his wounds. Then we can talk about everything else” (“A Big Heart Open to God: The Exclusive Interview with Pope Francis, *America* 209, September 30, 2013).

Is this what we are weighing when considering a new business arrangement – whether the merger, acquisition, or partnership gets us closer to the suffering so we can be a sign of mercy and hope? Are we looking at whether the reconstituted health system or health services will further our ability to reveal God’s healing and reconciling presence to the sick and suffering of the community?

Who We Must Care For – The Poor

The second theme is that of care for the poor. Perhaps more than any other pope in recent history, Pope Francis is intimately familiar with and committed to the plight of the poor. Indeed, he has stated that he wants a “Church which is poor and for the poor,” and has emphasized that all Christians are “called to find Christ in them, to lend our voice to their causes, but also to be their friends, to listen to them, to speak for them and to embrace the mysterious wisdom which God wishes to share with us through them” (*The Joy of the Gospel*, n. 198).

Not only has Pope Francis made the poor a central focus of his ministry, but also he repeatedly insists on and witnesses to a preferential option for the poor that is an essential component of living the Gospel values. As he explains:

“For the Church, the option for the poor is primarily a theological category rather than a cultural, sociological, political or philosophical one. God shows the poor ‘his first mercy.’ This divine preference has consequences for the faith life of all Christians, since we are called to have ‘this mind... which was in Jesus Christ’ (*Phil* 2:5). Inspired by this, the Church has made an option for the poor which is understood as a ‘special form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness.’ This option ‘is implicit in our Christian faith in a God who became poor for us, so as to enrich us with his poverty’” (*The Joy of the Gospel*, n. 198).

The significance of the pope’s words and deeds for Catholic health care cannot be mistaken. The poor needs to be a primary focus of our ministry if we are to be true to our mission and this goes beyond merely charity care. Furthermore, any organizational decisions we make - whether related to services offered to a community, consolidation of jobs, or new business arrangements – have to take into consideration and be influenced by how they will impact the poor. At times, it could be that the best business decision is the wrong ministerial decision and we have to look for another way. Yet, are we considering the poor when we seek to merge with, acquire, or partner with another organization? Are we asking how the new business arrangement will further our ability to care for the poor? Are we looking to go into medically underserved communities, especially rural and inner-city areas, or are we only considering growth opportunities with prospective partners that have significant revenues, positive margins, and good payer-mixes?

What We Must Also Focus On – Social Justice

The third theme is that of social justice. While continuing to address traditional moral issues, Pope Francis has raised our awareness of the profound social justice issues that we must also concern ourselves with and focus on in the moral life. Issues such as poverty, racial inequality, income disparity, climate change, trafficking, and migrants/refugees have all been subject to the pope's analysis and advocacy. In so doing, Pope Francis is broadening our moral scope and bringing into better focus issues that have long been pushed aside or overlooked. For the pope this is necessary so we can bring the Gospel to bear on the whole range of moral issues:

“The dogmatic and moral teachings of the church are not all equivalent. The church's pastoral ministry cannot be obsessed with the transmission of a disjointed multitude of doctrines to be imposed insistently... We have to find a new balance; ... The message of the Gospel, therefore, is not to be reduced to some aspects that, although relevant, on their own do not show the heart of the message of Jesus Christ” (A Big Heart Open to God: The Exclusive Interview with Pope Francis, *America* 209, September 30, 2013).

Some have taken comments such as this one to indicate Pope Francis is less concerned with issues of abortion, contraception or other sexual ethical issues. On the contrary, what the pope is attempting to do is awaken us to the profound social justice issues of our day and spur us to action by getting involved with the messiness in the world. As he describes:

“I prefer a Church which is bruised, hurting and dirty because it has been out on the streets, rather than a

Church which is unhealthy from being confined and from clinging to its own security... More than by fear of going astray, my hope is that we will be moved by the fear of remaining shut up within structures which give us a false sense of security, within rules which make us harsh judges, within habits which make us feel safe, while at our door people are starving” (*The Joy of the Gospel*, n. 49).

The emphasis placed on social justice by Pope Francis is important for Catholic health care in three ways. First, we need to be models of justice within our own organizations in terms of how we treat our employees, care for our patients, and act as corporate citizens, especially as this relates to how we invest our substantial resources and care for the environment. Second, we need to be a force for good in our communities by advocating for justice and working with others to undue and correct injustices. Finally, and most relevant for this essay, we need to be aware of the broader social justice issues engendered by new business arrangements and attend to these as much as we attend to issues related to cooperation. But do we think about such things? Are we looking at how employees will be affected by a merger, acquisition, or partnership in terms of job stability, wages, and benefits? Are we considering the impact on the communities we serve and the increase in our environmental footprint when we expand the size of our systems? Are we evaluating the prospective partner from a moral perspective beyond simply their involvement in abortion, contraception, and/or sterilization?

Mission/Ethics Discernment and Integration in New Business Arrangements

We have spent some time outlining these themes promoted by Pope Francis because they deepen our

understanding and awareness of the fundamental value commitments of Catholic health care. As we continue to reshape our ministry, as we should to meet the signs of the times, we must never let the need for size and sustainability blind us to the importance of these commitments. Living out these commitments is a necessary condition for realizing our mission of revealing God's healing and reconciling presence to the sick and suffering of the community. Consequently, every new business arrangement undertaken by a Catholic health care organization (CHCO) must be evaluated on the basis of whether it allows us to live out our fundamental value commitments.

Ensuring this will be the case in new business arrangements is no easy task. It will take senior leaders who are cognizant of, sensitive to, and willing to stand up for the fundamental value commitments at times when it might be easier to set them aside in the interest of getting the deal done. It is also going to take a better, more systematic approach or process to discernment on the front-end and integration on the back-end. With regard to discernment, we have to ask broader and deeper mission- and ethics-related questions about the transaction itself and about the prospective partner. Discussion around such questions should precede any other serious discussions, including those related to financial valuation and legal issues. The questions asked at this initial stage should center on whether we are advancing the mission and on justice concerns viewed with a preferential option for the poor. With regard to integration, we have to focus on ensuring our fundamental value commitments are embedded into the organizational structure and permeate throughout the culture, even as we incorporate and assimilate the best attributes of the other organization. We cannot simply be content that these commitments are being lived when a newly merged or acquired organization or one with whom we are partnering is abiding by our prohibitions. As

we have made clear, these are not the only issues with which Catholic health care is or should be concerned.

To address the concern around mission/ethics discernment and integration in new business arrangements, below we outline a process for consideration. We do so with the caveat that it should be taken as a first attempt or starting point of sorts that we hope others within Catholic health care will refine, expand upon, and adapt to address the unique circumstances and cultures of their organizations. Engaging the process will not guarantee every merger, acquisition, or partnership we enter into will advance the mission of Catholic health care. However, it will ensure we ask necessary questions for understanding our motivations and that we keep our fundamental value commitments at the center of our decisions.

Three-Phase Process

When a CHCO is considering entering into a formal business arrangement, especially with a non-Catholic party (either organization, physician(s) or other individual), senior leaders must ensure:

- The business arrangement furthers CHCO's Vision and Mission (this applies also to arrangements with Catholic parties);
- The prospective partner is compatible with CHCO from a Values perspective or, at a minimum, refrain from activities that are notably inconsistent with CHCO's Value Commitments;
- CHCO's Value Commitments are adopted at a level proportionate to the facts and circumstances of the particular business arrangement;
- The business arrangement meets cooperation guidelines and any medical interventions with restrictions are acceptably structured or "carved-out"; and

- A mission and ethics integration plan is developed prior to the close of the transaction and implemented effectively thereafter.

The process and timing for ensuring these critical features are met should be sequenced in three phases as depicted in **APPENDIX 1** and described below.

Phase 1: Assess Ability to Further CHCO's Vision and Mission, Compatibility with CHCO's Values, and Level of Adoption of CHCO's Value Commitments

This phase, which has three parts, is the most important in any discernment about a new business arrangement and should be the first order of business, preceding even financial and legal discussions. The focal point in this phase is: (a) whether and to what extent the business arrangement will further CHCO's Vision and Mission; (b) whether the prospective partner is compatible with CHCO from a Values perspective; and (c) at what level should CHCO's Value Commitments be adopted in the business arrangement.

A. Further CHCO's Vision and Mission (note: applies to all arrangements):

For this part of phase 1, several questions for discernment should be asked and reflected upon by senior leaders to reach a conclusion. These include but are not limited to the following:

- Will this business arrangement enable CHCO to increase access to care, especially for the uninsured and those in economically, physically, and socially marginalized communities?
- Will this business arrangement enable CHCO to improve community health as defined by key metrics related to mind, body, spirit and environment?
- Will this business arrangement enhance CHCO's ability to improve the patient

experience, manage the health of populations, and lower the total cost of care?

- Will this business arrangement improve CHCO's financial position and its ability to reinvest in the communities it serves?

If the answers to these questions are "yes," senior leaders may proceed to the second part of this phase.

If the answers are "no," generally the business arrangement **should not** be pursued. However, circumstances may arise, in limited situations, whereby CHCO's senior leaders may choose to discern further whether the business arrangement is worth pursuing if they believe it may be necessary for the overall good of the ministry or, alternatively, proceed cautiously to determine if the arrangement can be restructured.

B. Compatibility with CHCO's Values

Senior leaders need only ask one question in this part of Phase 1 and it is a critical question requiring an honest answer not clouded by the desire to move forward with the business arrangement.

- Does the prospective partner exhibit evidence of living core aspects of CHCO's Values or, at a minimum, refrain from activities that are notably inconsistent with CHCO's Value Commitments as outlined in **APPENDIX 2 (NOT INCLUDED HERE)**?

Ideally, the answer to this question should be "yes" and, if so, senior leaders may proceed to the third part of this phase. If, however, the answer is "no," meaning the prospective partner does not exhibit evidence of living core aspects of CHCO's Values, the arrangement may still be pursued if one of the following conditions is met: **(a)** the prospective partner refrains from activities that are notably inconsistent with CHCO's Value Commitments or

(b) CHCO will have majority control of the new company and can ensure adoption of its Value Commitments. If neither of these conditions is met, the business arrangement **cannot** be pursued any further. CHCOs must forgo entering into a formal business arrangement with a prospective partner when they do not have majority control and the prospective partner acts in ways that are notably inconsistent with CHCO's Value Commitments.

C. Adoption of CHCO's Value Commitments

Discernment in this part of phase 1 can be rather complicated because the extent to which CHCO's Value Commitments should be adopted will vary depending on the facts and circumstances surrounding a particular business arrangement. For instance, a merger with a hospital or medical group whereby CHCO will have majority control calls for a high level of adoption, whereas a minority investment in a technology company or health plan calls for a much lower level of adoption because many of CHCO's Value Commitments may not apply. As a general rule, the greater the control CHCO has in the new business arrangement and the more the prospective partner will be integrated into and/or associated with CHCO, the higher the level of adoption of CHCO's Value Commitments. At a minimum, CHCO should seek to incorporate the following Value Commitments into a new business arrangement whenever applicable:

- i. Creating a safe, just and diverse work environment and providing fair wages and benefits to all employees.
- ii. Protecting the sanctity of human life from conception to natural death and refraining from actions such as direct abortion, assisted suicide, euthanasia, and embryonic stem cell research.
- iii. Serving uninsured, underinsured, Medicaid, and other vulnerable populations. For non-health care providers, this value commitment

may be addressed through community outreach and charitable programs that seek to promote the health and well-being of the local community, with special emphasis on those living in poverty and at the margins of society. As an example, the technology company may establish a charitable donation program of equipment or software to schools in economically distressed neighborhoods or the health plan may coordinate a program to help uninsured individuals enroll in eligible insurance programs.

If the prospective partner is unwilling to adopt these minimal Value Commitments, when applicable, the business arrangement **cannot** be pursued, as they are central to the meaning and mission of Catholic health care. Of note, it is important that the level of adoption of CHCO's Value Commitments be discussed early in the proceedings with the prospective partner. Whatever level of adoption is deemed necessary based on the discernment must be tentatively agreed to in advance and be demonstrated in the contractual documents, which should also include a clause stating that CHCO has the right to mandate compliance with the Value Commitments if necessary and remove itself from the relationship for lack of compliance after an agreed upon time of non-compliance.

Phase 2: Identify Cooperation Issues Related to ERD-Restricted Interventions

At some point in the negotiations prior to a definitive agreement being signed, CHCO needs to identify if any cooperation issues will arise in the new business arrangement with a non-Catholic party that is engaged in medical interventions with restrictions as defined in the *Ethical and Religious Directives for Catholic Health Care Services* (ERD). Beyond issues related to the direct taking of life, which are addressed in Phase 1, ERD-restricted interventions typically

include services related to contraception, sterilization, and in vitro fertilization. Which ERD restrictions apply and what cooperation guidelines should be followed often varies depending on the nature and terms of the business arrangement. **APPENDIX 3** provides ethical guidance on the major types of business arrangements that senior leaders from strategy and other areas should use for discussion purposes with a prospective partner. However, a formal analysis addressing cooperation issues needs to be completed by a qualified and experienced ethicist before a definitive agreement is signed. In many business arrangements involving non-Catholic parties, ERD-restricted medical interventions can be acceptably structured, thereby allowing negotiations to proceed. In some cases, however, they cannot or the prospect of the new business arrangement causing scandal is too great that it should not be pursued.

Phase 3: Establish Mission/Ethics Integration Plan

After the definitive agreement is signed but before the closing, System Mission and Ethics should conduct an on-site assessment (if applicable) and document review to determine key integration opportunities based on the list of items detailed in **APPENDIX 4 (NOT INCLUDED HERE)**. The outcome of this phase should be a well-developed integration plan that clearly outlines the key mission and ethics components that will need to be developed under the new business arrangement as well as a timeline, communication plan, and a list of responsible parties that corresponds to each action item of the plan.

Appendix 1

Three Phases of Mission/Ethics Discernment and Integration in New Business Arrangements

PHASE 1: Assess Ability to Further CHCO's Vision and Mission, Compatibility with CHCO's Values, and Level of Adoption of CHCO's Value Commitments

A. Further CHCO's Vision & Mission (note: applies to all arrangements):

- i. Will this business arrangement enable CHCO to increase access to care, especially for the uninsured and those in economically, physically, and socially marginalized communities?
- ii. Will this business arrangement enable CHCO to improve community health as defined by key health indicators related to community health needs assessment?
- iii. Will this business arrangement enhance CHCO's ability to improve the patient experience, manage the health of populations, and lower the total cost of care?
- iv. Will this business arrangement improve CHCO's financial position and its ability to reinvest in the communities it serves?

B. Compatibility with CHCO's Values:

- i. Does the prospective partner exhibit evidence of living core aspects of CHCO's values or, at a minimum, is not engaged in activities that are notably inconsistent with CHCO's Value Commitments as outlined in **APPENDIX 2**?

C. Adoption of CHCO's Value Commitments

- i. To what extent should the Value Commitments of CHCO be adopted by the prospective partner? As a general rule, the greater the control CHCO has in the new business arrangement and the more the prospective partner will be integrated into and/or associated with CHCO, the higher the level of adoption of CHCO's Value Commitments. At a minimum, CHCO should seek to incorporate the following Value Commitments into a new business arrangement whenever applicable:
 - Creating a safe, just and diverse work environment and providing fair wages and benefits to all employees.
 - Protecting the sanctity of human life from conception to natural death and refraining from actions such as direct abortion, assisted suicide, euthanasia, and embryonic stem cell research.
 - Serving uninsured, underinsured, Medicaid, and other vulnerable populations. For non-health care providers, this value commitment may be addressed through community outreach and charitable programs that seek to promote the health and well-being of the local community, with special emphasis on those living in poverty and at the margins of society.

Discussions
Begin

← Negotiations →

Definitive
Agreement

Closing

Integration

PHASE 2: Identify Cooperation Issues Related to ERD-Restricted Interventions

- A. Determine the type and extent of cooperation issues related to the provision of ERD-restricted medical interventions by the prospective partner.
- B. Assess willingness and ability of prospective partner to effect carve-outs for the specified business arrangement as outlined in **APPENDIX 3**.

PHASE 3: Establish Mission/Ethics Integration Plan

- A. Conduct on-site assessment (if applicable) and document review prior to closing to determine key mission and ethics integration opportunities based on integration components detailed in **APPENDIX 4**.

Appendix 3

Ethical Guidelines for New Business Arrangements with Non-Catholic Parties

Prior to a definitive agreement being signed in any new business arrangement involving a non-Catholic party, CHCO needs to identify if any cooperation issues will arise as a result of the prospective partner engaging in certain medical interventions with ERD restrictions. The restrictions that may materialize are outlined below for the major type of business arrangements and are segmented into three sub-categories, namely: (1) “prohibited” services, which are **not** allowed under the arrangement and are **not** subject to carve-out; (2) “tolerable” services, which may be provided but are done so without the approval or support of CHCO; and (3) “carve-out” services, which may be provided if established by the non-Catholic party and the cooperation guidelines are met. Senior leaders from strategy and other areas should use the information below for discussion purposes when considering a new business arrangement. However, a formal analysis addressing cooperation issues should be completed by a qualified and experienced ethicist before a definitive agreement is signed.

Business Arrangement		Medical Interventions with ERD Restrictions			Cooperation Guidelines
		Prohibited	Tolerable	Carve Out	
Health System or Hospital *applies equally to Joint Operating Agreements wherein CHCO has a controlling interest	Sole or Majority Control	<ul style="list-style-type: none"> • Direct abortion • Euthanasia and assisted suicide • IVF • ESCR 	NA	<ul style="list-style-type: none"> • Direct contraception • Direct sterilization 	None of the prohibited or carve-out medical interventions can be provided because CHCO is the sole or majority owner and cannot legitimately distance itself morally from the wrongdoing. However, the former owner or a new, non-CHCO entity (e.g., community foundation) may choose to arrange for and provide the carve-out medical interventions in non-CHCO majority-controlled and/or identified spaces/buildings with no CHCO involvement.
	Minority Control	<ul style="list-style-type: none"> • Direct abortion • Euthanasia and assisted suicide • IVF • ESCR 	NA	<ul style="list-style-type: none"> • Direct contraception • Direct sterilization 	The carve-out medical interventions may be provided in the hospital if the following conditions are met: Governance: CHCO must have no more than a minority of board seats and CHCO board members must recuse themselves from decisions pertaining to the carve-out medical interventions. Finance: CHCO must not derive any revenue/profit from or provide direct funding for the provision of the carve-out medical interventions.
	Management	<ul style="list-style-type: none"> • Direct abortion • Euthanasia and assisted suicide • IVF • ESCR 	NA	<ul style="list-style-type: none"> • Direct contraception • Direct sterilization 	Management: CHCO must not oversee the management of the carve-out medical interventions. Such medical interventions should be managed by non-CHCO physicians and/or employees who report to a subset of the board that does not include CHCO members. Performance: CHCO employees and physicians must not provide the carve-out medical interventions as part of their employment agreement; the carve-out medical interventions must not be provided in CHCO majority-owned and/or identified spaces/buildings; and CHCO’s name should not be associated with the hospital if at all possible to avoid scandal.
	Affiliation	<ul style="list-style-type: none"> • Direct abortion • Euthanasia and assisted suicide • IVF 	<ul style="list-style-type: none"> • Direct contraception • Direct sterilization 	NA	Typically, hospital affiliation arrangements do not require any carve-outs because of the limited involvement of CHCO. However, if the affiliation agreement involves CHCO in the areas of governance, finance, management and/or the provision of tolerable medical interventions, the carve-out guidelines listed above would apply as appropriate.

<p>Physician Practice *encompasses all types of employment agreements with physicians, including professional service agreements, at any CHCO outpatient care site</p>	<ul style="list-style-type: none"> • ESCR • Direct abortion • Euthanasia and assisted suicide • IVF • ESCR 	<ul style="list-style-type: none"> • Direct contraception • Direct sterilization 	<p>NA</p>	<p>Though CHCO neither condones, approves of, nor supports counseling and medical interventions related to contraception and sterilization, these interventions, provided by CHCO physicians in outpatient settings, may be tolerated under the concept of professional moral agency and non-interference in the patient-physician relationship when deemed necessary by the physician due to medical indications and in consultation with the patient. As with other medical interventions, CHCO physicians are required to document in the patient’s chart that services or procedures related to contraception or sterilization are medically indicated. Of note, CHCO physicians are prohibited from marketing or advertising medical interventions related to contraception and sterilization. Additionally, print and other educational materials related to contraception and sterilization should not be displayed publicly.</p> <p>Employment agreements with CHCO physicians who, in order to provide the standard of care to their patients, deem it necessary to continue to provide medical interventions that are prohibited in CHCO hospital inpatient settings (e.g., direct sterilization), excluding those that involve the direct taking of life, should be structured as follows:</p> <p><u>Less than 100% employment</u> (e.g., 97.5% CHCO employment with 2.5% limited private practice capacity) with right of limited private practice capacity to provide inpatient prohibited medical interventions (excluding those that involve the direct taking of life) only at non-CHCO facilities. Insurance coverage provided by CHCO to such physicians may remain in effect and support services (e.g., scheduling, billing) may continue to be provided. Payments for medical interventions covered under these terms should be directed to the individual physician and not to the CHCO.</p>
<p>Health Plan</p>	<ul style="list-style-type: none"> • Euthanasia and assisted suicide 	<ul style="list-style-type: none"> • Direct contraception • Direct sterilization 	<ul style="list-style-type: none"> • Direct abortion • IVF 	<p>Member benefits related to contraception and sterilization may be covered by a CHCO-owned Health Plan or within a CHCO risk-based contract. Though CHCO neither condones, approves of, nor supports these benefits, the coverage of such benefits may be tolerated for two reasons, namely: (1) they are benefits for which coverage is required under federal law as part of the Patient Protection and Affordable Care Act; and (2) medical interventions related to contraception and sterilization are ethically permissible in limited circumstances within Catholic teaching making it unreasonable for health plans to absolutely exclude them as covered benefits and impossible for health plans to relegate coverage to only permissible circumstances without inappropriately intruding into the patient-physician relationship and usurping clinical decision-making authority. To avoid the possibility of scandal, however, CHCO should consider inserting a disclaimer into its health plan contracts and Summary Plan Descriptions that reads similarly to the following:</p> <p>"Any benefits covered by this plan that are related to contraception and sterilization are provided solely and exclusively by reason of legal requirement. Contraception and sterilization are contrary to Catholic moral teaching. CHCO does not approve, condone, or promote contraception or sterilization."</p> <p>If benefits for direct abortion and/or IVF are required to be covered under federal and/or state law, they should be carved-out and structured as follows to create maximum moral distance for CHCO:</p>

				<ol style="list-style-type: none"> 1. A separate insurer with its own license is enlisted to make decisions related to, accept payment for, assume risk for, contract with providers, and oversee the administration of the carve-out benefits. 2. A separate policy is established from that of the CHCO-owned Health Plan for the legally required carve-out benefits. 3. A note indicating the carve-out benefits are excluded within the CHCO-owned Health Plan product is added to informational materials, including Summary Plan Description, and the separate insurer develops its own informational materials and sends them directly to the members without CHCO involvement.
Pharmacy Benefit Management (PBM)	<ul style="list-style-type: none"> • Abortifacient medications (i.e., RU486) • Medications used solely for purposes of euthanasia or assisted suicide 	<ul style="list-style-type: none"> • Contraceptive medications 	NA	<p>Member benefits related to contraceptive medications may be managed by a CHCO-owned PBM. Though CHCO neither condones, approves of, nor supports these benefits, the management of such benefits may be tolerated for two reasons, namely: (1) they are benefits for which coverage is required under federal law as part of the Patient Protection and Affordable Care Act; and (2) contraceptive medications are ethically permissible in limited circumstances within Catholic teaching making it unreasonable for PBMs to absolutely exclude them as managed covered benefits and impossible for PBMs to relegate management to only permissible circumstances without inappropriately intruding into the patient-physician relationship and usurping clinical decision-making authority. To avoid the possibility of scandal, however, CHCO should consider inserting a disclaimer into its PBM contracts and Summary Plan Descriptions that reads similarly to the following:</p> <p>"Any benefits managed under this plan that are related to contraception are provided solely and exclusively by reason of legal requirement. Contraception is contrary to Catholic moral teaching. CHCO does not approve, condone, or promote contraception or contraceptive practices."</p>
Clinical Integrated Organization (CIO) or Accountable Care Organization (ACO)	<p>Services Prohibited for All Providers</p> <ul style="list-style-type: none"> • Direct abortion • Euthanasia and assisted suicide • ESCR 	<p>Other Services Prohibited for CHCO Providers</p> <p>Inpatient</p> <ul style="list-style-type: none"> • Direct contraception • Direct sterilization <p>Outpatient</p> <ul style="list-style-type: none"> • IVF 	<p>Other Services Prohibited for Non-CHCO Providers</p> <p>NA</p>	<p>CHCO may arrange for, structure, and be the sole owner of CIO and ACO arrangements that involve non-CHCO providers who provide medical interventions that are prohibited for CHCO providers, excluding those that involve the direct taking of life, if the following conditions are met:</p> <p>Governance: Non-CHCO providers must have at least a minority of board seats and CHCO board members must recuse themselves from decisions pertaining to medical interventions prohibited for CHCO providers.</p> <p>Finance: CHCO must not derive any direct revenue/profit from or provide direct funding for the provision of medical interventions prohibited for CHCO providers.</p> <p>Management: CHCO must not oversee the management of medical interventions prohibited for CHCO providers. Such medical interventions should be managed by non-CHCO providers who report to a subset of the board that does not include CHCO members.</p> <p>Performance: CHCO providers must not participate in or provide essential support to non-CHCO providers for the provision of medical interventions prohibited for CHCO providers; and the medical interventions prohibited for CHCO providers must not be provided in CHCO majority-controlled and/or identified spaces/buildings.</p>